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ABSTRACT

This report is designed to assist in the formulation of public policy as it relates to older people and their families by setting forth a comprehensive research-based framework to guide future public action in this area. It is intended for use by public officials, agency administrators, researchers, and academicians, as well as members of the private health and human service sector. Ten recommendations for public policy are listed and explained. A summary of the current knowledge base in the field of family care for older persons is provided in the areas of: (1) method of analysis; (2) characteristics of the elderly; (3) characteristics of family caregivers; (4) characteristics of family care; (5) problems associated with family caregiving; (6) family caregiving and formal intervention; (7) future demographic trends; and (8) existing policies and programs. Major findings are presented for each area, relevant issues are explored, and conclusions for policy and reseach are discussed. The appendices contain 54 data charts from research on family caregiving, the Soldo Study Caregiver Selection Methodology, New York City Dependency Study Material, Methodology for Dependency Ratios, and acknowledgements. (NRB)

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Family Caregiving and the Elderly

Policy Recommendations and Research Findings

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New York State Office for the Aging

Family Caregiving and the Elderly

Policy Recommendations and Research Findings

MARCH, 1983

CG 018398

New York State Office for the Aging

MARIO M. CUOMO, Governor

LOU GLASSE, Director

FOREWORD

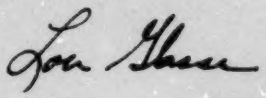
Older people in this country receive the majority of their care from family members. This fact has profound implications for the future of public policy. As the number of elderly continues to increase, efforts will intensify to determine the appropriate role of government in responding to the care needs of this population. Knowledge that the elderly are not abandoned but instead operate extensively in family networks will have a major influence on how our government responds to an aging society.

A variety of proposals already have been put forth to change public policy so that it reflects the active concern of family members for their older relatives. As we move forward in this area, though, it is important to keep in mind that we are venturing into new territory. Lost opportunities and possibly even damaging consequences can result if our enthusiasm to intervene into family life extends beyond the limits of our knowledge, is not clearly focused, or is guided solely by a desire to reduce health and human service expenditures.

This Report on Family Caregiving and the Elderly is designed to assist in the formulation of public policy as it relates to older people and their families. The Report brings together that which is actually known about family caregiving and sets forth a comprehensive research-based framework to guide future public action in this area.

In addition to making policy recommendations, the Report provides a synthesis of key research findings of family caregiving characteristics, problems and trends. Consequently, the document is more than a policy instrument. It is a research and program development guide as well. Among those who should find it of particular value are public officials, agency administrators, researchers, and academicians, as well as members of the private health and human service sector.

The Report builds on the recommendation of the New York State Governor's Health Advisory Council to support informal caregiving, of which family care is but one element. It also reflects the continuing commitment of the State Office for the Aging to advocate that government action be responsive to the needs of our older citizens.



Lou Glasse

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RECOMMENDATIONS

1. Public policy in health and human services should recognize that it is the family and not the government that provides most of the care to older people in this country. In this respect, government should see its caregiving role as being a supplement and a complement to that of the family.

While most older persons are in reasonably good health, a significant proportion experience problems which result in a dependence on others for assistance. The vast majority of all elderly in need of assistance resides in the community and receive most of their care from family members. The types of care provided by families include a variety of supportive activities, ranging from incidental chores to tasks critical to the maintenance of the elderly in their homes. Spouses and daughters are the main providers of family care.

Government is directly involved in the care of the elderly through the financing of a number of major public entitlement and service programs. Many of these programs, however, were enacted prior to our current understanding of the important role played by family members in the lives of older people. Consequently, public efforts to care for the elderly may not by fully sensitive to or integrated with those of the family. Nor are these efforts being carried out with an accurate perception of the relative contribution government is actually making in the care of the elderly.

Redirecting public policy so that it acts to supplement and complement the caregiving activity of families would make government programs more responsive to the needs and desires of the elderly and of the individuals who take care of them. Such an action would also be in the interest of government. The family unit appears to be a very effective vehicle for the provision of care. Family care substantially reduces the use of institutions by older people. Having government work to supplement the caregiving efforts of families would be an efficient use of scarce public resources.

2. Public policy should be designed to help families cope with the problems involved in providing care to their older relatives.

Family caregivers confront a wide variety of problems which include but may not be limited to emotional and financial strain, inconvenience, anxiety, and depression, as well as the joint demands of caregiving and employment. In addition, many caregivers of the elderly are old themselves and vulnerable to chronic health problems.

The extent to which these problems affect the quality of family care is not fully known. It is clear, however, that the capacity of many families to provide care is not unlimited. Evidence indicates that a breakdown of family caregiving may be related as much to a deterioration in the physical or mental health condition of the caregiver as to the condition of the care-recipient.

A policy designed to assist families in coping with the problems of caregiving could extend their capacity to provide care. There is evidence that government assistance could help a large number of families to keep older people at home who otherwise would be placed in institutions. The provision of government assistance to families could result in a net saving to the public for the care of the elderly in these families by reducing or delaying the use of more costly forms of care.

3. Any public policy directed at family caregiving should recognize the complex nature of families. It should also recognize the diversity found in families and family caregiving situations.

A family unit is more than a collection of individuals. It consists of a complex set of emotional, experiential, cultural, and in some cases religious features which can exert considerable influence on the behavior of its members. Family behavior is also conditioned by numerous external economic and social forces. An understanding of and an appreciation for the complex dynamics which shape the relationships that bind family members together is a necessary prerequisite for the development of sound public action in this area.

Just as no two individuals are exactly alike, neither are any two families. Family caregiving situations exhibit great diversity. The health, social and economic status of both caregivers and care-receivers as well as the types of problems encountered in caregiving and the environments in which these problems must be dealt all display immense variation. Ethnic factors contribute as well to the variations found in caregiving arrangements.

While our understanding of the family is far from complete, it is not premature to conclude that a single approach to the problems of family caregiving would be inappropriate. It is also important for policy makers to recognize that simplistic or superficial attempts to help families care for their older members can be rendered ineffective by larger forces at work both within and outside the family unit.

In attempting to respond to the diversity found in families and family caregiving situations, public policy need not be tailored to individual family units. Broad

categories of responses could be designed. These categories could be based on distinctions such as the economic or employment status of the caregivers, their relationship to the care-recipient, their household situation, or whether the care-recipient is experiencing a physical or mental health problem.

Perhaps the most important fact policy makers should keep in mind as they turn their attention to family caregiving is that not all family caregivers may want or need assistance from the government, not do all elderly have families available to provide care. This latter group is especially important since the needs of older people who have no relatives will not be adequately addressed by a policy designed to serve older people in family situations.

4. Government should begin planning for the likelihood that the burden of family care will increase in the future. It should recognize that this increased burden will not be distributed evenly over future decades or among caregivers of different age groups.

Although it is impossible to predict with precision the state of family caregiving in future years, projections indicate that there is likely to be an increase in the burden of care on the offspring of the elderly, beyond the level now being borne by this group. In future years, relatively fewer offspring will care for a greater number of frail older people.

Detailed examination of these trends reveal that this increase in burden will not be distributed evenly over future decades or among different groups of caregivers. The overall care burden posed by all elderly is not likely to increase until after 2010. In the interim, however, the offspring of the elderly age 85 and over — offspring who themselves average about 60 years of age — will likely experience a large increase in the burden of family caregiving compared to previous generations of caregivers of the same age.

In addition, an expected increase in female labor force participation may result in a diminished capacity in family caregiving, at least during the present decade. The effect of female labor force participation on family caregiving over the long term however is not known. It is also unclear at this time if projected increases in the proportion of offspring who are divorced will exert any influence on family caregiving in the future. The projected growth in the number of four generation families does not appear to be large enough to cause any major increase in relative terms in the problems associated with caregiving.

The ability to project the future can provide us with valuable lead time which, if used wisely, can help us avoid crisis situations. The Aging of America is a phenomenon that will require major adjustments on the part of all of our social and economic institutions. Effective planning can help ease the transition into an older society. The government should begin planning now so that we will be in the best position possible to cope with any shortfall of family caregiving capacity in the future.

5. Government concern with health care costs for the elderly should take into account the extent to which these costs are already being borne by the families of the elderly. The government should not attempt to reduce public costs in the health area by shifting a greater share of the burden onto family members.

The current concern over rising health care costs for the elderly has been defined primarily in terms of public health care expenditures. Little attention has been given to the value of the contributions being made by families in the care of the elderly.

Estimates show that the monetary value of family care for older people residing in the community is substantial and greater than that provided by public agencies. These estimates do not include the psychological and emotional costs associated with caregiving. Also, as noted above, the burden of family care is projected to increase in the future. Only by including the value of family care can the total cost of care for the elderly in our society be calculated.

Any effort by the government to reduce public health care expenditures by simply increasing family contributions to the care of the elderly would not reduce total costs but only shift a larger portion of these costs onto families, many of whom are already overburdened.

The real cause of rising health costs is the nature of our health care system. To control these costs, the government should concentrate on changing the health care system rather than placing a greater burden on families in the care of their older relatives.

6. Program development efforts in the area of family care should recognize the limitations of the existing knowledge base. Any major program implemented in this area should include a comprehensive evaluation component.

A number of program initiatives have already been undertaken in an effort to assist families in the care of their older members. Many of these efforts may be making an important contribution to the capacity of family caregiving. However, the current state-of-the-art cannot provide policy makers with the type of program information they need to make sound resource allocation decisions in this area. The effect of current initiatives on the family, the well-being of the elderly, or public costs has not been clearly documented. Neither has any serious attempt been made to assess the relative value of these initiatives.

Furthermore, little is known at this stage about the preferences of family caregivers towards different forms of government assistance. What is known though indicates that a wide variety of financial and service approaches should be tested before any definitive conclusions are drawn in this area. Also, greater emphasis should be placed on innovation.

Applying program techniques traditionally used to serve individuals may not be appropriate for helping family units.

A number of major program design issues also need to be resolved. Among them are agreement on a definition of family for program eligibility purposes, determining the best methods of accessing family caregivers, identifying how program effectiveness should be measured, and determining how ethnicity should be factored into implementation efforts.

Building an evaluation component into program activity will help us to better understand the effect of new initiatives on family caregiving. Such information would assist in the refinement of the knowledge base on family caregiving and help prioritize effective methods of assisting family caregivers for resource allocation purposes.

7. Program resources for family care should be targeted at those caregiving situations most in need of assistance.

To assure the most efficient use of public resources, efforts to help family caregivers should give priority to those caregiving situations most in need of help. While more research is needed before a complete list of target situations can be identified, the evidence to date suggests that the following groups should receive special attention: 1) households where the caregiver is a spouse, due to the vulnerability of these caregivers and financial problems, 2) households where the older care-recipient has moved in to live with a relative because of the high rates of impairment and institutional placement among the elderly in these situations, 3) family caregiving households with working wives, because of the tendency of these households to purchase institutional care for their older relatives, and 4) situations where the care-recipient is 85 years of age or over, because these elderly appear to pose the greatest burden for their children who in turn are likely to be facing the problems of old age themselves.

8. Program development efforts in family care should not be limited to new initiatives. Existing service and entitlement programs should be evaluated to identify and eliminate requirements which hinder the provisions of family care.

Most of the major public programs which now benefit the elderly were enacted prior to our current understanding about the important role played by family members in the care of older people. Many argue that provisions in these programs act to hinder family caregiving and thereby foster unnecessary institutional placement. One example is the requirement under Medicaid that an older person in an acute care hospital, in order to qualify for home care, must deplete a greater amount of personal resources than the level necessary to obtain institutional care. Another example is the one-third reduction in SSI benefits for persons living in the household of others, including relatives.

While it is known that the living arrangements and economic status of family members can affect an older person's eligibility and/or benefit level under some of our major public programs, the extent to which family caregiving is either enhanced or deterred by the requirements and/or structure of these programs is unclear. Action should be taken to identify and eliminate provisions in our current programs for the elderly which act as barriers to family caregiving.

9. Government should not act alone to assist family caregivers. The private sector can and should play an active role in this area. Private employers in particular can help family caregivers.

Any organization interested in advancing the public welfare can and should play a role in assisting family members to cope with the problems of caregiving. Family caregivers represent a large and diverse segment of society and no one entity, be it the government, the private non-profit service sector, the business community, or religious organizations, can expect to deal fully with the needs of these people. The challenges presented by a growing older population are of a magnitude that requires the contribution and cooperation of all parties. Government can provide leadership and funding, but it cannot and should not be expected to do everything.

Private employers can make a major contribution to assisting family caregivers since a large number of family caregivers are in the labor force. While the extent to which the joint demands of labor force participation and caregiving affects either the quality of family care or job performance is not known, it is known that the employment status of wives in households that provide support to older relatives does appear to reduce family caregiving capacity. Caregiving households which include working wives are much more likely than other such households where the wives are not working to purchase institutional care for their impaired elderly relatives than provide the care themselves.

Employers can assist in designing and testing a variety of methods to help family caregivers who are also working. Some of the methods available to employers in this area are counseling, inclusion of the cost of some forms of care for the elderly, such as respite, under employee health plans, as well as establishing flexible work schedules and special leaves of absence. Just as many employers undertook measures to help working mothers to cope with child rearing, they can now take action to assist employees engaged in caring for older relatives.

10. A national clearinghouse should be established to assist in the coordination of research on family caregiving and in the dissemination of findings. More public and private sector resources should be devoted to research on family caregiving for the elderly.

One of the most difficult tasks associated with the development of this Report was the identification and

compilation of information of family care. A considerable amount of time and energy went into reviewing the literature and consulting with experts before a clear understanding of the existing knowledge base could be established. The absence of a central clearinghouse on family caregiving which acts as a comprehensive source of up-to-date information is a major barrier to the systematic conduct of research in this area.

While much is known about family care, numerous and important information gaps still exist. This Report identifies a number of critical areas for future research, including the need for more information on such things as the characteristics of caregivers to older people who live alone, the nature of the family decision-making process surrounding institutional placement, as well as a better understanding of the psychological and social dimensions of caregiving. There is a particular need for longitudinal research to determine how family caregiving situations change over time.

One of the most important unanswered questions in this area concerns the extent to which provision of formal care affects family caregiving. It is unlikely that the government will make a major resource commitment to family caregiving programs before a better understanding of the interactive effects of formal and informal care is developed. Greater public and private resources must be invested in research on the elderly and families if society is going to be able to respond effectively to the challenges of a growing older population.

Summary Of The Current Knowledge Base

1. Method Of Analysis

Family care for older persons is often classified as an activity that falls under the general category of care known as informal supports. Defined broadly, informal supports encompass any type of assistance provided to elderly or disabled adults by non-government sources including family members, friends and neighbors as well as private organizations. While a substantial amount of information has been written on the subject of informal supports, including family care, a close review of the literature reveals that most of the published material in this area draws from a limited research base.

In an effort to distill and clearly identify what is actually known on the subject of family supports, it was decided that the analysis in this Report would rely to the greatest extent possible on primary data generated by research studies which have used recognized sampling techniques to produce findings. Additional data were drawn from publications issued by the U.S. Census Bureau and the Social Security Administration as well as from a select number of privately authored reports and special governmental studies.

Using data from the above sources, detailed profiles of the elderly and their family caregivers were constructed. Descriptions of what is known about the caregiving relationship were also developed, focusing on those aspects of the relationship with greatest relevance to policy makers. Because of the static nature of the sample data used in these descriptions, projections were used to gain insight into how expected changes in different demographic variables might affect family care for future generations of elderly.

Following the data compilation and analysis, a series of conclusions were drawn for the areas of policy development and research. These conclusions were used as a basis for developing a comprehensive set of recommendations to govern public involvement in the area of family care. Rather than the standard method of referencing, all data used in the analysis is contained in the Report, either in the body or Appendix. This was done to facilitate future family care. Future research is also facilitated by the Report's identification of the areas where substantial gaps exist in the knowledge of family care.

For operational purposes, a conceptualization of families, cited by Shanas in her national study of the elderly, was used in developing this Report. According to this perspective, the families of the aged can be characterized as a kinship system consisting of a network of mutual supports among individual households of persons related by blood or marriage. The network extends not only across households but also across generations of related kin and functions indirectly and non-coercively for its members in performing tasks of socialization and support.[1]

Finally, the term caregiving as used in this Report refers to any type of helping activity performed for an older person ranging from incidental chores to tasks considered essential to the maintenance of the person in a home environment. The term does not include financial help, unless specified. Caregiving is used interchangeably with the words assistance and support. The terms older and elderly are also used interchangeably and refer to being age 65 and over.

2. Characteristics Of The Elderly

Major Findings

- The elderly comprise a large group of people whose marital status, living arrangements and health characteristics display great variation, especially with age and sex.
- While a majority of the elderly are in reasonably good health, a significant minority experience chronic health problems which result in a dependency on others for various forms of assistance.
- The elderly who are most likely to be in greatest need of assistance are those individuals who are over age 85, are widowed, have very low incomes, or live with a relative other than a spouse.
- Older people with health problems who are living alone tend to seek out living arrangements with other relatives. Such arrangements appear to provide many older persons with a true alternative to institutional placement.
- A slight majority of all older people are married and thus have a spouse available as a potential caregiver. The proportion of older people who are married, however, declines sharply with age. The vast majority of all elderly have surviving children.

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[1] Shanas, E. "National Survey of the Aged: Final Report," University of Illinois at Chicago Circle, AoA Grant 90-A-369, 1977, Chapter IV.

- Older people with families are much less likely to be institutionalized than elderly persons without families.

Numbers and Proportions

An understanding of who the elderly are is an essential ingredient in the development of any policy which attempts to influence their well-being. According to the 1980 Census, there are approximately 25.5 million people aged 65 and over in the United States representing slightly over 11 percent of the total population. Over 60 percent of all older people are between the ages of 65 and 74, 30 percent fall into the 75 to 84 range with about 9 percent being 85 years of age and older. The average life expectancy for a female aged 65 in 1980 was 18.7 years and for males 14.3 years. Because women tend to outlive men, the majority of older people are women and they make up an increasing larger percentage of the older age groups among the elderly. While females account for 57 percent of all persons aged 65 to 74, they make up 63 percent of the 75 to 84 group and 70 percent of the 85 and over group. (Table 1)

TABLE 1: U.S. Elderly Population By Age, Sex, and Marital Status, 1980

Age/Sex	Numbers	Percentage of Total Elderly Population (65+)	Percentage Married
Total 65+	25,544,133	100	53
Males	10,302,601	40	74
Females	15,241,532	60	39
Total 65 - 74	15,577,586	61	63
Males	6,755,199	26	79
Females	8,822,387	35	50
Total 75 - 84	7,726,826	30	43
Males	2,865,974	11	69
Females	4,860,852	19	27
Total 85+	2,239,721	9	21
Males	681,428	3	44
Females	1,558,293	6	11

Source: NYS Office for the Aging, data from U.S. Bureau of Census, *1980 Census Supplementary Report, PC80-81*; Social Security Administration, *Actuarial Study No. 84*, 1980.

Family Structure

The family structure of the elderly, especially in terms of its size and make-up, has an obvious impact on the level of support the elderly receive from family members. As Table 1 indicates, a slight majority or 53 percent of all older persons are married and thus have a spouse available as a potential source of care. As would be expected though, the proportion of elderly who are not married increases significantly with age. Almost four-fifths of all persons age 85 and older have no spouse. Also, because of the discrepancy in life expectancies, older women at all ages are much less likely to be married than men. Within the total age 65+ population, 39 percent of the women and 74 percent of the men are married. Within the age 85+ group, however, only 11 percent of women are married as compared with 44 percent of the men.

The extent to which older people have surviving children was documented by Shanas in her 1975 study "National Survey of the Aged."[2] While most of the elderly have surviving children, a large minority or about one in five have no children. Of those with surviving children, one quarter have one child, one quarter have two, and one-half have three or more children. Some 13 percent of the elderly had six or more children in 1975. (Chart 1)*

Shanas also found in her study that approximately 4 percent of persons age 65 and over in 1975 had at least one parent still alive. Shanas refers to these elderly persons as the generation in the middle since they usually must balance the demands of an aged parent with those of adult children and grandchildren at a time when their own energy level, health status, and financial status may be declining. About half of the parents of elderly persons are living with one of their adult children, about a quarter live in institutions, and a quarter live independently in the community. (Chart 2)

Living Arrangements

Although living with one's spouse is the most common living arrangements for the elderly as a group, women [illegible]e very old are more likely to have some other liv[illegible]ngement. Overall, among the older population [illegible] in the community, more than one-half of the elderly (53 percent) live with one's spouse, 30 percent live alone, 15 percent live with relatives other than a spouse, and 2 percent live with a nonrelative. At all ages women are less likely than men to live with a spouse and therefore more likely to either live alone or with other relatives. (Table 2)

Comparing differences in living arrangements by age, persons age 75+ are much more likely than persons between the ages of 65 and 74 to live with other relatives (21 percent vs. 11 percent). Shanas found in her national sample that even when unmarried persons only are examined, a similar pattern holds true with 59 percent of these unmarried persons in the oldest age groups living alone compared to 70 percent of the unmarrieds in the younger cohort. (Chart 3) This tendency to live with others in advanced age has been associated with the need for assistance and is examined below in greater detail.

[2] Shanas, Ethel, "The National Survey of the Aged", University of Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

* All Charts appear in Apendix A

TABLE 2:
Living Arrangements of Elderly By Age and Sex, 1980

Living Arrangement and Age	Both Sexes (percent)	Men (percent)	Women (percent)
Living with spouse			
65 and over	53	75	37
65 - 74	60	78	47
75 and over	38	67	21
Living alone			
65 and over	30	15	41
65 - 74	25	13	35
75 and over	39	21	50
Living with relatives other than spouse			
65 and over	15	8	20
65 - 74	11	7	15
75 and over	21	10	27
Living with nonrelative			
65 and over	2	2	2
65 - 74	2	2	2
75 and over	2	2	2

Note: Excludes elderly in institutions
Source: NYS Office for the Aging, data from U.S. Bureau of Census

The Need for Assistance

The presence of a chronic limitation in activity is often used as an indicator of the need for assistance among the elderly. The 1977 National Health Interview Survey[3] conducted by the National Center for Health Statistics found that the prevalence of activity limitation rises dramatically with age; the elderly are 4½ times more likely to suffer activity limitation than those under 65. The association with age is even more dramatic when the elderly population is subdivided. The percentage of elderly who are unable to carry out a major activity increases from 14.4 percent among 65 to 74 year olds to 32.9 percent for those age 85 and over. (Table 3)

Information on the distribution and level of need for assistance among the elderly population by age, sex, marital status, and living arrangements is available from a study conducted by Soldo on "Family Caregiving and the Elderly."[4] Using a national probability sample conducted in 1976 by the Bureau of the Census and a 14 point Need for Assistance Scale, Soldo found that among the elderly, those persons most likely to be in greatest need of assistance are individuals who are over age 85, are widowed, or are living with a relative other than a spouse. Soldo also found that older women are more likely to be in need of assistance than older men, regardless of age, marital status, living arrangement or extent of need. This sex differential in need can be attributed in large part to the greater longevity of women. (Table 4; Charts 4, 5)

The relationship between the need for assistance and living arrangement was a subject of special investigation by Soldo. Specifically, she examined whether impairment had any demonstrable effect of its own on the living arrangements of older people. Her sample for this investigation was representative of all older unmarried white women residing in the community.

Soldo found a definite relationship between health status and living arrangements in her sample and her evidence indicates that older people with health needs who are living alone tend to seek out living arrangements with other persons. The effect of health on living arrangements in Soldo's study did not vary by level of personal income, implying that the need for assistance is just as likely to result in a multi-person living arrangement for high income as for low

TABLE 3:
Persons with Activity Limitations Due to Chronic Conditions By Age, 1977

	Total	Under 25	25-44	45-64	65-74	75-84	85 & Over
Total Population (in thousands)	212,153 (100%)	91,249 (100%)	55,280 (100%)	43,357 (100%)	14,259 (100%)	6,652 (100%)	1,354 (100%)
No limitation of activity	86.5	95.8	90.4	76.9	61.4	51.6	36.8
Limited, but not in major activity	3.1	1.8	2.9	4.5	5.4	6.0	6.6
Limited in kind or am't of major activity	6.7	1.9	5.0	12.3	18.7	22.3	23.6
Unable to conduct major activity	3.6	0.3	1.4	6.2	14.4	22.0	32.9

Notes: excludes institutionalized elderly
Sources: 1977 National Health Interview Survey [NCHS, 1978, and unpublished data]

[3] National Center for Health Statistics, "Health Interview Survey", U.S. Department of Health and Human services, 1977.
[4] Soldo, Beth, "Family Caregiving and the Elderly: Prevalence and Variations", Kennedy Institute, Georgetown University, AoA Grant No. 90-AR-2124, Final Report, 1980.

TABLE 4: Percent Distribution of Need for Assistance for Elderly Persons By Type of Living Arrangement and Sex, 1976

Type of Living Arrangement/Sex	No Assistance Needed	Minimal Assistance Needed	Moderate Assistance Needed	Extensive Assistance Needed	Total
Head of Family Household					
Male	93	1	1	4	100%
Female	84	4	5	7	100%
Spouse of Household Head	87	3	4	6	100%
Household Head Living Alone or with Nonrelatives					
Male	94	2	2	2	100%
Female	89	3	4	3	100%
Relative of Household Head Other than Spouse					
Male	79	3	3	14	100%
Female	71	4	7	18	100%

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulations prepared by the Center for Population Research, Georgetown University, under AoA Grant No. 90-AR-2124. Data from 1976 Survey of Income and Education, U.S. Bureau of Census.

income persons in the study sample. These findings help account for the lower incidence of impairment among elderly living alone and imply that in many cases when a family takes in a older relative, they are actually providing the older person a true alternative to institutional living.

Shanas, in her 1975 national survey, examined the relationship between impairment and income. Her findings reveal that older people with high levels of impairments are the most likely of all elderly persons to be poor. Over half of the elderly in her sample who scored highest (7 or more on a 12 point impairment scale) were persons in the lowest income quartile. (Chart 6)

A major investigation conducted in 1977 by Gurland sheds additional light on the nature of impairment among the elderly. As part of a larger "United States —United Kingdom, Cross-National Geriatric Community Study," Gurland examined the phenomenon of "Personal Time Dependency" in a sample representative of all non-institutionalized persons in New York City. Personal Time Dependency is defined as the state of dependency requiring time consuming help from others, including family members.

Gurland's study[5] identified a number of conditions which proved to be significantly related to dependency in older age. These factors were assigned by Gurland into three categories: possible causes of dependency; possible effects; and possible disadvantages, which are defined as situations which could complicate the ability to cope with dependency. The factors identified as being the most significant possible causes included: dementia, heart disease, neurological disorder, total physical illness, immobility and perceptual impairment; the most significant possible effects included inadequate activities in addition to depression; and possible disadvantages included financial status. Gurland found a relationship between higher levels of dependency and the following conditions: dementia, total physical illness, immobility and inadequate activities. (Chart 7)

Gurland also found in his sample an underrepresentation (fewer than might be expected proportionate to the population) of dependent persons in the following groups: never-married, divorced and separated persons; those living alone; those living in good neighborhoods; men; and those born in Western Europe. An overrepresentation was found among: blacks; Puerto Ricans; widowed women; Italians; and those living in poor neighborhoods. Gurland notes that the underrepresentation of dependency in certain groups living in the community could possibly be attributed to a weakness in their support system and conversely, that the overrepresentation of dependency in certain groups could be related to the presence of a strong community support system. (Chart 8)

Vulnerability to Institutional Placement

While only about 5 percent of the elderly reside in institutional settings at any one point in time, over 20 percent of all older people can expect to spend some time during their life is such a setting.[6] The National

[5] Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

[6] Kastenbaum, R., and Candy, S.E. 1973. The 4% fallacy, a methodological and empirical critique of extended care facility population statistics. *Int. J. Aging and Hum. Develo.*, 4, 15-21.

Center for Health Statistics, using the National Health Interview Surveys and the 1973-74 National Nursing Home Survey,[7] has generated information which provides insight into the factors associated with institutional placement. Rates of institutional placement for older persons according to their age, sex, marital status and living arrangement prior to institutionalization are displayed in Charts 9, 10, and 11. As would be expected from previous findings on the distribution of impairment among the elderly, the rates of placement increase dramatically with age. Also, at all ages women are more likely than men to be placed in an institution.

Of major significance to the issue of family care is the fact that older people who are married have the lowest rates of institutional placement of any group of elderly. This finding suggests that spouses are very effective caregivers. The role of children in keeping their parents out of institutions is reflected in the finding reported by Shanas that while four out of five older people have at least one surviving adult child, almost half (46 percent) of the institutionalized elderly are childless.[8]

TABLE 5: Rates of Institutionalization for Elderly By Age and Living Arrangement Prior to Institutional Placement, U.S., 1973-74

Age/Living Arrangement	Nursing Home Population[a/]	Non-institutionalized Population[b/]	Estimated Institutionalized Rate/1000
Total 65+			
With Spouse[c/]	117,100	10,988,500	11
Alone	357,200	5,619,400	60
W/Other Relatives	458,700	3,476,900	116
W/Non-Relatives	32,600*	412,600	73
65 - 74			
With Spouse	30,100	8,087,300	4
Alone	50,500	3,024,300	16
W/Other Relatives	74,200	1,650,200	43
W/Non-Relatives	8,300*	209,600	38
75 - 84			
With Spouse	54,800	2,648,800	20
Alone	145,000	2,168,100	63
W/Other Relatives	173,000	1,328,700	115
W/Non-Relatives	12,000*	150,200	74
85+			
With Spouse	32,200	252,400	113
Alone	161,700	427,000	275
W/Other Relatives	207,500	498,000	294
W/Non-Relatives	12,200*	52,800	189

Notes: [a/] Estimates based on data from the 1973-74 National Nursing Home Survey.
[b/] Data from the 1973-74 Health Interview Surveys.
[c/] Assumes married persons live with spouse.
* Figure does not meet NCHS standards of reliability or precision.

Source: NYS Office for Aging; based on data from NCHS, Table A-1: Compilation of Institutionalization Rates for Elderly: U.S. 1973-74.

Table 5 shows that the highest rates of institutionalization among the elderly, regardless of age, are experienced by those elderly who are living with relatives other than a spouse. This finding is also consistent with the previous information on impairment which shows that older people living with other relatives experience proportionally more impairment than other groups of elderly. Recalling Soldo's conclusion that many older people who are living with relatives may have sought out such arrangements as alternatives to institutionalization suggests that some of these alternatives may in fact be temporary deterrents to institutional placement.

Conclusions for Policy and Research

- Public policy should recognize that there is no single or simple solution to the assistance needs of older people. The diversity found within the elderly population requires a wide range of responses.
- Program resources should be targeted at subgroups of the elderly identified as being particularly vulnerable to impairment and/or institutional placement. Such targeting should take into account the extent to which family support systems compensate for the vulnerablitity of people in these groups.
- Special attention should be given to those situations where older people are living with relatives other than a spouse since these family arrangements appear to be a critical component in the continuum of care between community and institutional services.
- Although most older people have family members available as potential caregivers, it is important for policy makers to remember that a large number of the elderly have no spouse and/or children.
- The need for assistance among the elderly has been defined primarily in terms of physical health factors. More attention should be given to examining the effect of various social, psychological, and environmental factors on the need status of older people.

3. Characteristics Of Family Caregivers

Major Findings

- Family members, particularly spouses and daughters, are the main providers of personal assistance to older people. Family members are also the source of care preferred by the elderly.
- Beyond their identity, little is known about the general characteristics of family caregivers. Nationally representative data is available to some extent on caregivers who live in the same household as the care-recipient, but not on family caregivers of older people who live alone.

[7] NCHS, "1973-1974 National Nursing Home Survey", U.S. Department of Health and Human Services, Washington, D.C.

[8] Shanas, E. and G. Maddox, 1976. Aging, health, and the organization of health resources. In Binstock, R. and E. Shanas (eds.). *Handbook of Aging and the Social Sciences*. New York: Van Nostrand Reinhold Co.

TABLE 6: Magnitude and Distribution of the Support System: All Providers

Type of Provider	Order of Provider				
	Primary	Secondary	Tertiary	Quarternary	Total
	Percent Distribution				
Spouse	29	6	7	-	19
Daughter	34	25	11	25	29
Other Family	14	35	30	25	22
Friend	3	14	22	25	9
Private Nurse	-	3	4	-	1
Private Aide	3	-	-	-	2
Private Home Helper	5	7	7	-	6
Public Nurse	1	-	-	-	1
Public Aide	1	1	-	-	1
Public Home Helper	5	3	-	-	4
Other	5	6	19	25	7
Total	100	100	100	100	100

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S.-U.K. Cross-National Geriatric Council of Greater New York, October, 1978.

- Among those households where the caregiver and care-recipient reside together, rates of poverty are highest for households that are non-white or consist of older couples living alone.
- Many family caregivers of the elderly are old themselves and vulnerable to chronic health problems.
- A large number of family caregivers are in the labor force. Individuals in professional or managerial occupations are more likely to work and provide care at the same time than persons in other occupations.

Primacy of Family Caregivers

The research on informal supports has consistently found that most older people in this country receive the vast majority of their care from family members. Gurland found, for example, that 70 percent of all the care received by the dependent elderly in his sample comes from the family. If the focus is restricted to primary care, which is defined by Gurland as care considered critical to the maintenance of the older person at home, the family contribution increases to 77 percent of the total. Spouses and daughters are the most important sources of family care for the elderly. (Table 6)

The research also shows that the family is the source of care preferred by the elderly. A major investigation of the preferences of older people towards different types of care providers was conducted by Cantor in 1970 as part of her "Study of the Inner City Elderly."[9] Her sample for this study is representative of approximately 400,000 older persons living in the inner neighborhoods of New York City. For ten hypothetical need situations, respondents were asked to identify to whom other than spouse they would most likely turn for assistance. The situations involved help with a variety of health, financial, housekeeping and emotional matters. Possible choices for source of care included a child, other relative, friend/neighbor, and formal organization or a representative thereof, as well as a "no one or myself" option.

Cantor's study documented a clear order of preference with respect to source of care. While there was some variation across different need situations, kin, primarily children, emerged as the support element of first choice followed by friends and neighbors with formal organization and others generally ranking last, even after the "no one but myself" option.

The notable exception with formal organizations was that they were cited as the preferred source in providing financial assistance to cover large medical expenses. Cantor's data also revealed that for older persons with either no children or children who did not live in close geographic proximity, friends and neighbors appeared to act as preferred choice "substitutes" for these absent children. (Chart 12)

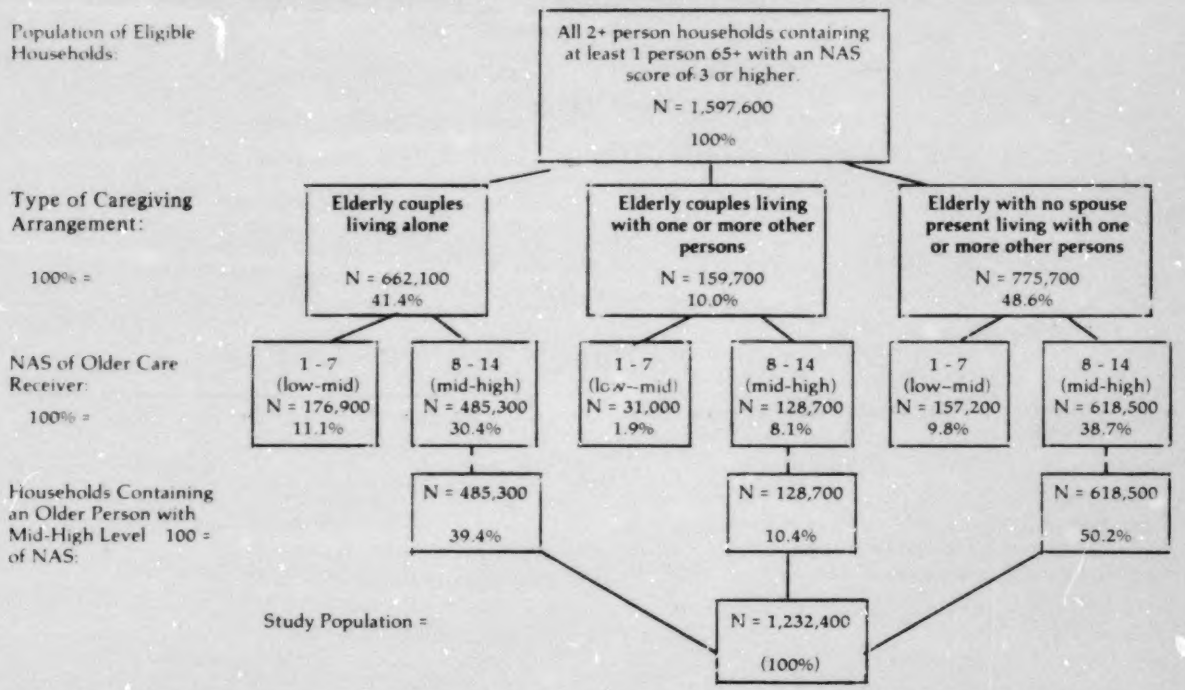
Beyond the identity of the caregivers of older people, little additional information is available on the characteristics of these people. Research on informal supports has focused almost exclusively on the care-recipient as the unit of analysis. Data on caregivers has been obtained in most cases indirectly from questions asked of the care-recipients, and where interviews have been conducted with the providers, the study samples have not been representative of larger groups.

In an attempt to overcome this informational problem and begin constructing a data base on the caregivers of older people, the U.S. Administration on Aging contracted with Georgetown University in 1978 to conduct research on the characteristics and pre-

[9] Cantor, Marjorie, "The Elderly in the Inner City", New York City Office for the Aging, AoA Grant No. AA-4-70-089-02, Final Report, 1974.

[*] scored 8 or higher on a 14 point Needs Assistance Scale

FIGURE 1: Distribution of Households By Type of Caregiving Arrangement and Needs Assistance Score (NAS) of Care Receiver in Soldo Study


Population of Eligible Households:
All 2+ person households containing at least 1 person 65+ with an NAS score of 3 or higher.
N = 1,597,600
100%
Type of Caregiving Arrangement:
100% =
Elderly couples living alone
N = 662,100
41.4%
Elderly couples living with one or more other persons
N = 159,700
10.0%
Elderly with no spouse present living with one or more other persons
N = 775,700
48.6%
NAS of Older Care Receiver:
100% =
1 - 7 (low-mid) N = 176,900 11.1%
8 - 14 (mid-high) N = 485,300 30.4%
1 - 7 (low-mid) N = 31,000 1.9%
8 - 14 (mid-high) N = 128,700 8.1%
1 - 7 (low-mid) N = 157,200 9.8%
8 - 14 (mid-high) N = 618,500 38.7%
Households Containing an Older Person with Mid-High Level 100 = of NAS:
N = 485,300
39.4%
N = 128,700
10.4%
N = 618,500
50.2%
Study Population =
N = 1,232,400
(100%)

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

valence of family caregiving. Soldo directed this project which produced some of the information on impairment among older people referenced earlier in this Report. Using an involved methodology and data from a 1976 national probability survey, Soldo was also able to generate extensive information on caregivers.

The method used by Soldo to identify the caregivers of the elderly is explained in Appendix **B**. Her data is not representative of all caregivers but only of those who are acting as the primary caregivers of moderately to severely impaired older persons residing is the same household as the caregiver. Thus the caregivers of older persons living alone were omitted from her analysis. Also, excluded are secondary caregivers as well as those caregivers providing help to older persons with low impairment levels. Despite these limitations, Soldo's data and analysis represent a major advancement in the state-of-the-art on caregivers and her study can be used to gain considerable insight into the characteristics of a large number of family caregivers.

General Distribution

In the Soldo study on family caregivers, three types of multi-person household caregiving arrangements were indentified: elderly couples living alone, elderly couples living with one or more relatives and/or non-relatives, and unmarried elderly living with one or more relatives and/or non-relatives.* Of such households containing at least one moderately to severely impaired older person, 50 percent consist of unmarried elderly living with others, 40 percent are elderly couples living alone, and the remaining 10 percent are arrangements where elderly couples are living with others. The distribution of these three types of arrangements, both before and after the stratification of cases by the older person's impairment level, is contained in Figure 1.

The distribution of caregivers found in the Soldo study by their living arrangement, sex, and race is contained in Table 7. The relationship of these caregivers to their care-receivers is identified in Chart 13. From this data it can be calculated that overall these

* Only one in every thousand study households in the sample used by Soldo consists of individuals living with a non-relative.

caregivers are predominately female (70 percent) and tend to be old themselves (50 percent are over age 65), with almost half being a spouse (49 percent) of the care-recipient. Of the female caregivers, 39 percent are spouses and about 41 percent are age 65 or older. For male caregivers, 73 percent are spouses and 72 percent are age 65 or older.

The number of older caregivers is very important since these people are taking care of persons who are moderately to severely impaired while being vulnerable themselves to the limitations associated with age. In total, about 21 percent of the caregivers in this group are age 75 and older. In households where older couples live alone, over half of the male and one quarter of the female caregivers are age 75 or older.

A wife is the person most likely to be the caregiver in households where elderly couples live alone, although husbands do account for 47 percent of the caregivers in such arrangements. In situations were elderly couples live with others, a spouse continues to be the primary care provider but the gender difference becomes more pronounced with the number of husbands providing care declining to about 32 percent. Only 5 percent of the primary care providers in these second type of situations are persons who are not spouses.

In households where unmarried elderly live with others, the caregivers are prodominately female, accounting for 83 percent of the total. Unfortunatley the data with which Soldo was working did not allow her to clearly identify in all cases the relationship of non-spouse caregivers to the care-recipients; as a result, information on the percentages of daughters (and sons) who are caregivers is not completely distinguishable from those listed as other relatives.

As far as race is concerned, non-white caregivers appear more often in situations involving either unmarried elderly or elderly couples living with other than those where elderly couples live alone. Soldo suggests that this pattern may reflect a greater tendency on the part of non-whites to establish multi-generational living arrangements. Also, a higher proportion of non-white caregivers are female than is true for whites.

Health Status

Most of the caregivers of the elderly do not appear to be functionally limited. Only 4.5 percent of the caregivers in Soldo's sample are impaired, with 2.5 percent falling in the moderate to severe range. The most vulnerable caregivers are in households where elderly couples live alone. In such households, nearly 7 percent of the caregivers have some type of impairment with about 5 percent having moderate or high incapacity levels. These latter caregivers — moderate to highly impaired persons taking care of a spouse with similar impairment levels — are members of what Soldo classifies as mutual-support arrangements and appear to be in extremely vulnerable situations (Chart 14).

Employment and Economic Status

The data in Table 8 shows that Soldo found that a large majority (70 percent) of the caregivers represented by her sample are not in the labor force, with this proportion being about the same for both males and females. However, a slight majority (51 percent)

TABLE 7: Age and Race Composition of Caregivers in Soldo Study By Type of Caregiving Arrangement and Sex of Caregiver (Base Number in Hundreds)[1]

	Elderly Couples Living Alone		Elderly Couples Living With Others		Unmarried Elderly Living With Others		All Caregiving Arrangements*		
Age Group	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Both Sexes**
18-29	0.0	0.0	1.8	0.9	8.0	6.4	2.4	3.9	3.5
30-49	0.0	1.0	0.0	8.1	30.9	27.6	8.5	17.7	14.9
50-64	6.5	21.7	7.8	29.2	44.2	46.7	17.0	37.5	31.3
65-74	41.1	50.3	53.3	38.6	11.0	12.7	34.2	26.6	28.9
75+	52.5	26.9	37.1	23.2	6.0	6.5	37.9	14.3	21.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
MEAN AGE	74.8	69.8	72.9	65.4	52.6	53.7	68.5	59.7	62.4
Race									
White	94.5	93.7	81.1	79.9	83.6	84.7	90.0	86.9	87.9
Non-White	5.5	6.3	18.9	20.1	16.4	15.3	10.0	13.1	12.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	(2274)	(2579)	(430)	(857)	(1021)	(5164)	(3725)	(8600)	(12,325)

*Estimated by the New York State Office for the Aging from Soldo data.

[1]Weights used in analysis of caregivers are those associated with data on individuals rather than those of households in which care is provided.

Source: Soldo, Beth "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

TABLE 8: Employment Status of Caregivers in Soldo Study By Sex, Type of Caregiving Arrangement and Age of Caregivers (Base Number in Hundreds)

Sex and Employment Status	Type of Arrangement and Age of Caregiver: Elderly Couples Alone		Elderly Couples With Others		Un-Married Elderly Living with Other		All Situations*		All Situations All Ages*
	-65	65+	-65	65+	-65	65+	-65	65+	
Male									
In Labor Force:	49.1	13.2	64.3	11.3	70.9	11.3	67.5	12.8	28.0
Not in Labor Force:	50.9	86.8	35.8	88.7	29.1	88.7	32.5	87.2	72.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	(147)	(2127)	(41)	(389)	(846)	(174)	(1034)	(2690)	(3724)
Female									
In Labor Force:	25.0	5.9	23.7	8.7	52.6	10.9	47.5	7.7	31.2
Not in Labor Force:	75.0	94.1	76.3	91.4	47.4	89.1	52.5	92.3	68.8
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	(586)	(1993)	(327)	(530)	(4159)	(994)	(5072)	(3517)	(8589)
Both Sexes*									
In Labor Force:	29.7	9.7	28.0	9.8	55.7	11.0	50.9	9.9	30.3
Not in Labor Force:	70.3	90.3	72.0	90.2	44.3	89.0	49.1	90.1	69.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	(733)	(4120)	(368)	(919)	(5005)	(1168)	(6106)	(6207)	(12,313)

*Estimates by New York State Office for the Aging, based on Soldo data.

Source: Soldo, Beth "Family Caregiving to the Elderly: Prevalence and Variation", based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

of caregivers under age 65 are employed or looking for work. As would be expected, males under the age of 65 have the highest rates of labor force participation (68 percent) of any group of caregivers. A large number (48 percent) of female caregivers under age 65 are also in the labor force. Only about 10 percent of caregivers over age 65 are in the labor force with slightly higher proportions of older males in the labor force than older females (13 percent vs. 8 percent).

Comparing across household types, the caregivers in situations where unmarried older persons live with others are the most likely to be employed. Overall, 47 percent of these caregivers are in the labor force with the percentages for males and females in this category being 61 and 47 percent respectively. For all groups, males were more often employed than females.

With respect to occupational status, Soldo found that individuals in professional or managerial occupations are most likely to work and provide care at the same time. Soldo suggests that this finding may imply that the "opportunity cost" associated with giving up a job to devote full time to providing care may influence a caregiver's employment decision. Those persons who have high "opportunity cost" are more likely to be in the labor force and providing care than those in lower paying occupations.

Finally, Soldo examined the per capita income of the sample caregivers by their type of household, labor force status, and race. The data show that regardless of employment status or household type, the income of non-white caregivers is substantially lower than that of whites in similar circumstances. Soldo also found that non-white caregivers have the highest rates of poverty across all household types, with the difference being especially dramatic for the non-white caregivers of elderly couples living alone and with others. When both white and non-white caregivers are combined, rates of poverty as well as near poverty are highest for older couples living alone. (Table 9, Chart 15).

Conclusions for Policy and Research

- Public policy should recognize that family members play a large role in providing assistance to older persons.
- Public policy should also recognize the diversity found among family caregivers and caregiving situations. Special consideration should be given to spouse caregivers who are vulnerable to health and financial problems.
- Given that many caregivers are in the labor force, employers can play an important role in identifying and responding to the needs of family caregivers.
- In order to develop a complete understanding of who the family caregivers of the elderly are, much more research needs to be conducted on the characteristics of these caregivers, especially on

TABLE 9: Percent of Caregivers in Soldo Study of Poverty and Near Poverty Households By Type of Caregiving Arrangement and Race (Base Number in Hundreds)

Ratio of Family Income to Poverty Level	Type of Arrangement and Race								
	Elderly Couples Living Alone			Elderly Couples Living With Others			Unmarried Elderly Living with Others		
	White	N-W	Total	White	N-W	Total	White	N-W	Total
Below Poverty Level	9.3	17.8	9.8	4.6	28.6	9.3	4.4	23.7	7.4
Near Poverty[1]	12.9	26.5	13.7	6.7	5.9	6.5	6.3	21.2	8.6
N	(4567)	(286)		(1035)	(255)		(523)	(955)	

[1]100-124% of Poverty Level

Source: Soldo, Beth "Family Caregiving to the Elderly: Prevalence and Variation", based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

those caregivers providing assistance to older people who are living alone.

- Additional research is also needed to determine if the joint demands of caregiving and labor force participation affects either the quality of family care or the job performance of the caregiver.

4. Characteristics of Family Care

Major Findings

- Family members provide a wide range of assistance to their older relatives. The amount and intesity of care from family members increases with the level of impairment in the care-recipient.
- A large number of older people receive care from family members which is comparable to the care provided in institutional settings.
- Ethnicity appears to affect the provision of family care.
- The monetary value of family care to older people residing in the community is substantial and greater than that being provided to these elderly by public agencies.

Types and Frequency of Care

The research clearly documents that older people receive a wide range of assistance from family members. Shanas, in her national study, looked at three different types of care received by older persons who had been in bed during the previous year, but were not severely impaired. She found that nearly two-thirds of these elderly receive assistance from their spouses or children in the areas of housework and meal preparation, and almost three-fourths get help in shopping. (Table 10)

TABLE 10: Proportion Reporting Each Source of Help, Persons Aged 65 and Over Ill in Bed Last Year, By Sex: 1975[a]

Sources of Help	Task								
	Housework[b]			Meal Preparation[b]			Shopping[b]		
	Men	Women	All	Men	Women	All	Men	Women	All
Spouse	66	22	37	71	23	40	62	25	38
Child in household	9	15	12	7	13	11	9	16	14
Child outside household	6	18	14	6	19	14	10	25	20
Others in household	4	5	5	5	5	5	4	5	5
Paid helper	7	9	8	2	3	3	2	2	2
Social services	0	*	*	1	1	1	0	*	*
Relative outside household	2	6	5	2	6	5	3	8	6
Non-relative outside household	*	4	3	4	9	7	5	12	9
None or self	10	29	23	10	31	24	9	15	13
Number of cases (weighted) =	(501)	(941)	(1442)	(501)	(944)	(1446)	(501)	(941)	(1442)

*Less than 1% after rounding.

[a]Excludes bedfast persons. The proportions of person ill in bed last year are: Total 26, men 22, and women 28.

[b]Percentages do not sum to 100 since more than one response could be given.

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

TABLE 11: Level of Support Services Given to Dependent Persons[a] Residing in Community (Percent Distribution)

Institutional Equivalent of Support Service	Severity of Dependency[b]							
	Minor		Moderate		Severe		Total	
	Percent	Number of Cases	Percent	Number of Cases	Percent	Number of Cases	Percent	Number of Cases
Limited Home Care	23	31	9	11	2	2	34	44
Adult Home	5	7	24	30	5	8	34	45
Nursing Home (HRF & SNF)	0	0	2	2	30	41	32	43
Total	28	38	35	43	37	51	100	132

[a]Persons classified as Personal Time Dependents.

[b]Personal Time Dependency.

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study," in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

Gurland's study of the elderly in New York City entailed an extensive analysis of the types of care received by dependent older persons from both formal and informal sources. In his study, care activities were clustered into groups equivalent with the kinds of services typically given by institutions to their residents. Two levels of institutional services were identified: adult home care and skilled nursing (or health-related facility) care. A minimal level of services similar to that given in limited formal home care but not institutional settings was also identified. The service components contained in these "institutional equivalent" categories are listed in Appendix C.

Gurland found that among all older persons classified as dependent is his community sample, almost one-third (32 percent) received the kinds of services and support that would be equivalent to the services of a skilled nursing or health-related facility; another one-third (34 percent) received the type of care provided in an adult home; and the final third (34 percent) required care less than that provided in an adult home. (Table 11)

Gurland also found, as would be expected, that the distribution of all types of assistance varies considerably with the age and dependency level of the care-recipient. As age and dependency increase, so does the intensity of types of services provided. About one-half (46 percent) of his dependent persons under age 75 received the lowest level of supportive services. Above age 75, over three-fourths (78 percent) of the dependent persons received care normally provided in an adult home or nursing home. Overall, only a minority received care equivalent to that of a nursing home until after age 90 when over three-fourths (77 percent) of all such persons were getting the most intensive types of care. (Charts 16 and 17)

The variation reported by Gurland in the types of care provided to different groups of dependent older people in the community can not be traced precisely to family providers since his reported data does not disaggregate family care providers from other sources of care.[10] Nevertheless, inferences can be drawn from his study about the general pattern of family care since, as reported above, 70 percent of all care and 77 percent of the primary care for his dependent sample comes from family members.

The time commitment and the level of skill required of the providers of primary care to the dependent elderly were also examined by Gurland in his New York City study. These care providers were found to be for the most part involved in care activity for short sessions (8 hours a week) with daily care (40 hours a week) being the next highest category. In terms of skill level, most providers were engaged in housekeeping activities, followed by personal care (e.g., bathing, grooming, feeding, etc.) then administrative/errands. Combining time and skills together, primary care providers appear to be involved mainly in daily personal care, followed by half daily housekeeping and then short session administrative/errands. Gurland interprets these findings to indicate that relatively low levels of skills offered on a part-time basis are sufficient to provide adequate support for many older persons to remain in the community. (Chart 20)

[10]The GAO study of older people in Cleveland (see footnote 14) reported a similar variation in the intensity of care provided with different levels of impairment, but also failed to clearly distinguish between family care and other sources. Shanas reported increased contact between older people and their children with increased impairment among the elderly. (Charts 18 and 19)

Ethnic Variations

Several researchers have examined ethnic factors in relation to family care. Cantor examined the influence of ethnicity on family caregiving as part of her study of the Inner City Elderly. Her findings show that while whites, blacks, and hispanics all exhibit significant patterns of family caregiving, the Spanish elderly are most likely to be living in multi-generational households and to have a higher level of interaction with their children. Cantor found no significant difference among ethnic groups with regard to the total number of relatives with whom respondents maintain an active relationship. In terms of the caregiving relationship Cantor's analysis indicated that ethnicity is a significant determinant in the case of the Spanish, but being white or black was not significantly related to the level or form of the help given. Being Spanish was also found to be an almost consistent predictor with respect to the types of help rendered, including the giving of gifts by children, help with the tasks of daily living and assistance when ill.[11]

Two other studies have examined ethnicity and family care and both have found situations which appear to differ from those reported by Cantor. These differences, however, can be attributed partially, if not entirely, to the use of different sampling techniques. Unlike Cantor, neither of these two studies which are reported below used a probability sample.

Morris, Sherwood and Gutkin in their 1981 study "Meeting the Needs of the Impaired Elderly: The Power and Resiliency of the Informal Support System"[12] used a sample of 699 older people, a high proportion of whom were frail and living alone. Included in the total sample were two ethnic subsamples of 102 urban blacks and 50 urban Puerto Ricans. In determining major subgroup differences related to the resiliency of the caregiving relationship the researchers reported that the urban black elderly in their sample are significantly less likely to have someone upon whom they believe they can rely for help indefinitely. The urban elderly blacks also have lower proportions of helpers who would not want to be replaced. The Puerto Rican subsample was found to have significantly lower proportions of strong informal support networks. Less than half of the Puerto Ricans were very or fairly confident that the help being provided by family and friends would continue to be increased should the need arise. The Puerto Rican sample also contained significantly higher percentages of persons with children described as doing very much less than they should for the frail elderly parent. (Charts 21 and 22)

Sussman examined the ethnic variable in relation to expressed attitudes toward family caregiving. In his 1979 Cleveland study on "Social and Economic Supports and Family Environments for the Elderly,"[13] he found blacks on the average to be somewhat less willing than whites to accept an older relative into their home and more likely to see government rather than family as being primarily responsible for the care of the elderly. Sussman also found blacks to be more receptive to economic than service oriented caregiving incentives, while whites are evenly divided on the desirability of economic and service incentives. It should be noted that the blacks interviewed in the Sussman study were of a higher economic status than the norm. (Chart 23)

The Value of Family Care

Economists assess the value of any activity broadly as involving all known cost impacts both negative and positive to all parties affected either directly or indirectly by the activity. Costs are not restricted to those where an exchange of money occurs, but also include intangible effects such as psychological and emotional costs as well as lost opportunities resulting from the investment of time and resources in one type of activity as opposed to others.

The state-of-the-art in assessing the value of family care is at a relatively unrefined stage. Only three studies identified to date have attempted to estimate the value of family care from actual experience, and all have limited their calculations to the monetary cost of the services provided. Each used a different methodological approach, resulting in varying estimates. Nevertheless, the information generated by these studies which are examined below provides an important base for determining the relative contribution made by families in the care of dependent older persons in our society.

The GAO study on the "Well-Being of Older People in Cleveland"[14] examined the cost of services used to maintain older people in their home. The study was conducted in 1976 and drew on a sample of 1,609 people representative of all people age 65 and over residing in Cleveland. The costs of services were divided between those provided by families and friends and those provided by an outside agency. Values were assigned to services provided by family and friends according to the cost for the same services provided through an agency, taking into account the frequency

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[11]Cantor, M., "The Extent and Intensity of the Informal Support System Among New York's Inner City Elderly — Is Ethnicity a Factor?", in *Strengthening Informal supports for the Aging*. Community Service Society of New York, NY, 1981.

[12]Sherwood, S., "Meeting the needs of the Impaired Elderly: The Power and Resiliency of the Informal Support System," Hebrew Rehabilitation Center for the Aged, Boston, 1981.

[13]Sussman, Marvin B., "Social and Economic Supports and Family Environments for the Elderly", Bowman Gray School of Medicine, Wake Forest University, 1979.

[14]"The Well-Being of Older People in Cleveland, Ohio". U.S. General Accounting Office; 1977.

with which the family or friends performed the service. As Table 12 shows, the average monthly value for services provided by both sources varied with the impairmment level of the older person, with family and friends incurring the majority of service costs at all levels.

TABLE 12: Average Monthly Costs of Services Provided By Friends, Family, and By Agency for Different Impairment Levels

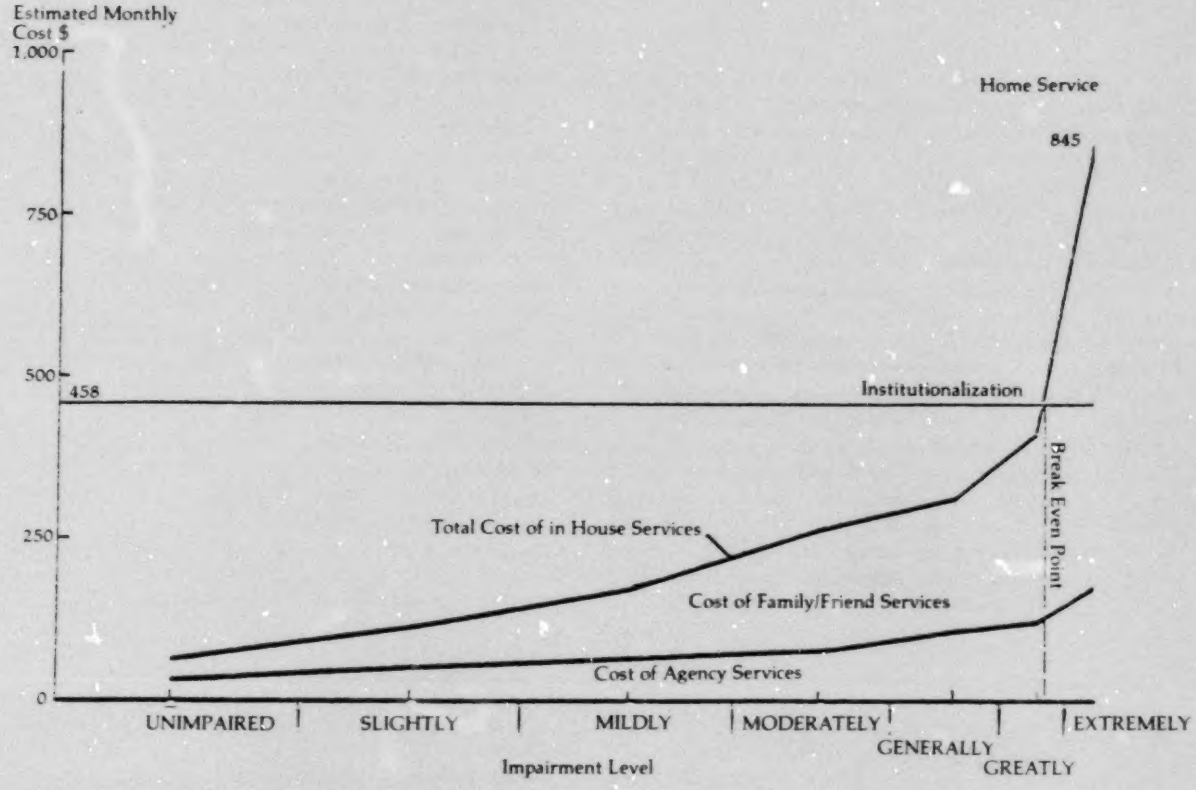
Impairment Level	Family/Friends	Agency	Total	Proportion Family/Friends
Unimpaired	$ 37	$ 26	$ 63	.59
Slightly impaired	63	47	110	.57
Mildly impaired	111	65	176	.63
Moderately impaired	181	78	259	.70
Generally impaired	204	100	304	.67
Greatly impaired	287	120	407	.71
Extremely impaired	673	172	845	.80

Source: *Home Health — The Need for a National Policy to Better Provide for the Elderly*, Washington, D.C., U.S. General Accounting Office, 1977.

The Cleveland study also compared the service costs for non-institutionalized and institutionalized groups to determine at what impairment level the total cost to keep an older person at home (including the value of services provided by family and friends) equals the cost to institutionalize the person. The study findings are displayed in Figure 2 and indicate that at all impairment levels, except in the greatly impaired range, it is less expensive to keep older people at home. In considering public costs alone, however, even when an older person is greatly impaired home care is less expensive since the family is incurring a large percent of the total care cost for such persons. If an average individual being kept at home in the Cleveland study at the greatly or extremely impaired level were to be institutionalized, the public cost of care for that person would increase from only about $150 to over $450 per month.

Another approach to estimating the cost of caring for older persons in the community was undertaken by Gurland who estimated values for the services provided by primary providers in support of his dependent

FIGURE 2: Comparison of Estimated Monthly Cost of Home Services and Institutionalization at Each Impairment Level Per Individual



Source: *Home Health — The Need for a National Policy to Better Provide for the Elderly*, Washington, D.C., U.S. General Accounting Office, 1977.

elderly sample. As noted above, 77 percent of all primary services identified in the Gurland study come from family members. Again this does not mean the 77 percent of the cost of such services can be attributed to the family. Nevertheless, a general indication of the overall magnitude of cost borne by families in the care of their elderly can be ascertained from these estimates.

In the Gurland study, tasks performed by primary caregivers were rated according to skill levels required to carry out the activity. Five categories of skills were identified including nursing skill, personal care skill, housekeeping skill, administrative and errand skill, and companionship skill. Each of these skills were valued at wage levels reported by the New York State Department of Labor in October, 1977. These wage levels were applied to the number of hours reported for each task to determine the total value of the support provided by primary caretakers. The value of these services was found to average about $303 per month per older individual, or $3636 per year. The aggregate value of primary care provided to older dependent people living in the community in 1977 in New York City was estimated to be approximately $1 billion annually. (Chart 24)

Gurland reported in his study that the major "dollar-volume" of support services provided bey primary caretakers in the area of daily personal care, full-time personal care, daily housekeeping, and half daily housekeeping, in descending order. These types of services account for the care of roughly half of the dependent sample, but over seven-eights of the cost. He also reported that the majority of services provided in these high dollar-volume catogories come from informal sources and of the formal services involved, half come from privately paid sources.

The third and final cost estimate identified for family care was calculated by the Maryland State Office for Aging for a Family Support Demonstration Program."[15] In this case, the costs of home care for severely disabled elderly was calculated by applying the minimum wage ($3.35 per hour) to the number of hours which family members in their program reported they were engaged in caregiving activity. The average imputed value of the family care for a severely impaired older person was estimated to be $968 per month. Adding in the estimated cost of housing, food, medical care and other expenses, the State Office for the Aging valued the total average cost of home care for such an individual to be about $1,243 per month. (Chart 25)

Since each of the three estimates identified above were developed in different years, adjusting them to same year dollar values allows for a somewhat better comparison. Such an adjustment can be achieved to some extent through the application of an inflation factor to each estimate. Using Cost-of-Living factors to bring the values to July 1982 dollars shows the average monthly cost for the care component of family activity under the three estimates to be: $480 for Gurland's dependent elderly care; $474 for GAO's greatly impaired elderly care and $1110 for GAO'S extremely impaired elderly; and $1051 for the Maryland's severely impaired elderly.

Conclusions for Policy and Research

- Public policy should recognize that families are devoting considerable resources to the care of the elderly.
- Government concern with health care costs for the elderly should take into account the extent to which these costs are already being borne by the families of the elderly. Efforts to reduce public costs in this area by simply shifting a greater share of the burden onto family members should be avoided.
- Measurements of the value of family caregiving should be expanded to include more than just caregiving activity. The social and psychological costs associated with family caregiving should also be taken into account.
- More research is needed to determine the actual effects of family caregiving on the physical, mental, and social well-being of the older care-recipients as well as the caregivers.
- More information needs to be obtained before we can develop a full understanding of the effects of ethnicity on family caregiving.

5. Problems Associated With Family Caregiving

Major Findings

- Family caregivers are confronted with a wide variety of problems, including but not limited to emotional and financial strain, inconvenience, anxiety, depression, and joint demands of caregiving and employment. The presence of such

[15] Whitfield, S., "Maryland State Office for the Aging Family Support Demonstration Program", in *Financial Incentives for Informal Caregiving*. Community Council of Greater New York, New York City, 1982.

problems in a caregiving situation appears to be related to factors such as the age, sex and relationship of the caregiver to the care-recipient.

- The employment status of wives which provide support to older relatives appear to have a definite effect on the use of institutional care. Households which include working wives are more likely than households where wives are not working to purchase institutional care for their impaired elderly relatives than provide the care themselves.
- The presence of children does not appear to have a major effect on the willingness of families to take in and care for an older relative. The vast majority of all family households with impaired older members do not have children and where they do, caregiving does not appear to be significantly affected.
- The extent to which the joint demands of labor force participation and caregiving affects the quality of family care or job performance is not known.
- There appears to be a direct relationship between the inconvenience associated with caregiving and the decision of a family to consider institutional placement for an older member.
- While little is known about what causes a breakdown in the ability of a family to provide care, evidence suggests that breakdowns may be influenced as much by changes in the status of the caregiver as in the care-recipient.

Labor Force Participation

Perhaps more so than any other factor, labor force participation, especially on the part of women, has been cited as having a possible negative impact on family caregiving. The Soldo study provides the most extensive evidence to date on the employment status of family caregivers and the effect of labor force participation on caregiving.

As noted previously, Soldo found that a large percentage of caregivers in multi-person households appear to be coping with the joint demands of work and caregiving. A slight majority (51 percent) of all caregovers under age 65 were in the labor force. The rates for male and female caregivers under age 65 were found to be 68 and 48 percent respectively. Unfortunately, her data did not allow her to examine how well these caregivers were coping with their care situation nor did it provide insight into the effect of work on the overall duration of caregiving.

One of the most significant findings to come out of Soldo's study on family caregivers relates to the employment status of wives in caregiving households. Specifically, she examined those households headed by persons under age 65 which contribute to the support of an older relative to determine if the employment status of wives in these households affected the provision of care. She found that those households where the wife is in the labor force and there is no other woman over 18 years of age present in the household are much more likely to purchase institutional care for their elderly relatives as opposed to providing care themselves than either families in which the wife is in the labor force but there is at least one other woman present, or families in which the wife does not work. Soldo also found that while the presence of a woman other than the working wife substantially reduces a family's propensity to purchase institutional care, such families are still more likely to make such a purchase than families in which the wife does not work. (Chart 26)

Presence of Children and Other Impaired Adults

The presence of minor children or other impaired adults have been cited as factors contributing to the inability of families to provide care, or at a minimum, to the burden of caregiving. Soldo found that the vast majority of caregiving households have neither a minor child nor another impaired adult present. For multi-person caregiving arrangements other than those where an older couple lives alone, only 24 percent have children under 18 years of age present and 6 percent have impaired persons other than the older care-recipient. (Chart 27)

In comparing households which provide care with those that purchase institutional care, Soldo found that the presence of children does not appear to have a major effect on the direct provision of care. The presence of another impaired person, on the other hand, appears to increase significantly the likelihood that a household will provide rather than purchase care. Soldo attributes this latter finding to possible "economics of scale" for households providing care to more than one person. Again, as in the case of employment, Soldo was not able to examine how the presence of child or other impaired person in the household affects the qualitative aspects of care provision. (Chart 26)

Attitudes and Inconvenience

Teresi, Bennett and Wilder examined the relationship between the perceived inconvenience associated with caregiving, family attitudes towards the older person, and the decision to consider institutional placement in their study "Personal Time Dependency and Family Attitudes".[16] For their investigation, data were collected from 162 key supports of a random subsample of the New York City study conducted by Gurland. A key support was defined as the person to whom the older person turned in times of trouble, the person seen most frequently and generally relied upon most in decision-making. All but 16 of the key supports were family members. Twenty percent of

[16] Teresi, R. Bennett, and D. Wilder, "Personal Time Dependency and Family Attitudes"; Columbia University, 1978.

the elderly in the sample lived alone, two percent with non-family and 78 percent with a family member.

Four scales were used to ascertain family perspectives on their attitudes towards the older person, their family orientation, perceived inconvenience in caregiving, and the extent to which they had considered institutional placement for the older person. A copy of the four scales is contained in Appendix C.

The investigators found a direct relationship between dependency in the older person and family attitudes. As the older people in the sample were more impaired, the attitudes of their caretakers towards them were less positive. A direct relationship was also found between dependency in the elderly and the family's consideration of placing the person in an institution, although this latter relationship was not as strong as the first. Almost 24 percent of the dependent elderly in their sample had key supports who had yet to consider institutional placement. (Charts 28 and 29)

The findings in this study showed that among the variables studied, inconvenience proved to be the only factor that could serve as a clear predictor of the decision to consider institutional placement. Inconvenience also proved to be the best predictor of family attitudes towards the older person. The analysis also identified dependency in the older person as the most significant predictor of inconvenience. From these findings, the authors concluded that inconvenience, more so than the attitudes of the family towards the older person or their family orientation, can best explain the decision to institutionalize and that this convenience us best explained by dependency in the older person. (Charts 30—35)

Anxiety and Strain

A study on "Factors Associated with Strain Among Family, Friends and Neighbors Caring for the Frail Elderly",[17] conducted in 1981 by Cantor provides valuable insight into how various types of strain and anxiety affect different caregivers. Her sample was comprised of 111 primary informal caregivers of marginal income older persons in New York City receiving publicly subsidized homemaker services. Of the total caregiver sample, 33 percent were spouses, 31 percent were children, 19 percent other relatives, and 12 percent friends or neighbors.

Respondents were asked a series of questions pertaining to different types of emotional and financial stress and personal anxiety. With respect to anxiety, the single greatest worry reported by all groups concerned the health condition of the dependent person. After this common concern, considerable differences were found among the groups. Among spouse caregivers, the greatest worry after health is financial followed by the morale of the ill spouse and than by worry about obtaining sufficient help in the house. Children worry more about obtaining sufficient help for their frail parent with concern about financial matters ranking last. A pattern similar to children is found in the responses of other relatives. (Chart 36)

In terms of strain, of the total sample almost two-thirds indicated that they experienced a great deal of emotional strain with caregiving, about one half (47 percent) reported physical strain, and nearly one third (31 percent) felt financial strain. As with anxiety, Cantor found that the burden of caregiving affects different groups of caregivers in different ways. In all three categories, however, spouses appeared to experience the greatest degrees of strain, ranking physical and emotional equally followed closely by financial strain. Children reported the second highest degrees of strain and reported being affected the most by emotional strain, followed by physical and last by financial strain. (Chart 37)

Depression

One of the major findings to emerge from the Gurland New York City study is that personal time dependency in the elderly is significantly related to depression. Gurland found that of the 30 percent of all older people who are dependent on others for care, 13 percent had conditions of depression warranting clinical attention and treatment, almost twice the level found among non-dependent elderly.

Of potentially great importance to the issue of family caregiving is that this depression appears to be somewhat "contagious", possibly affecting other people who live with or provide care to a depressed older person. Gurland found that among persons 65 years of age and over who were independent, the frequency of depression more than triples when a companion is dependent (4 percent compared to 14 percent). Gurland found that the significant links in his study between dependency and depression appear to be, in descending order: physical illness, immobility, inadequate activities, financial disadvantage, heart disorders, perceptual impairments, and dementia. (Charts 38—41)

The Breaking Point

The specific types of threshold conditions beyond which family members cease to provide care to their older relatives have yet to be clearly identified in the research, although a study on "The Aging Family" conducted in 1965 by Brody does offer some preliminary evidence. Her sample consisted of 85 older applicants to a nursing facility who had at least one surviving adult child. Case records were reviewed to determine the major precipitating factor which caused the applicant and/or family to request admission.

Brody's findings are presented in Table 13. The major reason for seeking institutional placement by this study sample was the mental or physical impairment

[17] Cantor, Marjorie, "Factors Associated With Strain Among Family, Friends and Neighbors Caring for the Frail Elderly", Paper presented at the 34th Annual Gerontological Society Meeting, Toronto, 1981.

TABLE 13: Major Reasons Given for Application to Nursing Home By Persons With At Least One Surviving Adult Child. (N=85)

Reason	Men		Women		Total Both Sexes	
	No.	%	No.	%	No.	%
Applicant's mental or physical Impairment	7	28	31	51.7	38	44.7
Mental or physical impairment of applicant's spouse	6	24	1	1.7	7	8.2
Death of applicant's spouse	8	32	6	10	14	16.5
Severe illness of applicant's adult child	1	4	3	5	4	4.7
Severe illness of adult child's spouse	-	-	6	10	6	7
Death of applicant's adult child	1	4	4	6.7	5	6
Death of adult child's spouse	-	-	3	5	3	3.5
Multiple deaths and illnesses among adult children and adult children's spouses [a]	-	-	2	3.3	2	2.3
Other (bad neighborhood, loneliness, relationship problems)	2	8	4	6.7	6	7
Total N	25		60		85	99.9

[a] One applicant lost two adult children and a son-in-law through death and a third adult child was acutely ill; the other applicant's two adult children, a son-in-law and a grandchild were all severely ill.

Source: Brody, Elaine, "Aging Family", Paper presented at the 19th Annual Meeting of the Gerontological Society, New York, NY, November, 1966.

of the applicant, being cited in almost 45 percent of the cases. About 25 percent of the applicants indicated their request for admission was related to the death or severe mental or physical impairment of the applicant's spouse. The death or severe illness of an adult child or an adult child's spouse was listed by almost 24 percent of the cases, with 7 percent giving other reasons for their application.

Comparing differences between sexes, Brody found 56 percent of the men but less than 12 percent of the women stated they were applying because of the death or severe impairment of a spouse. The loss or severe illness of an adult child or an adult child's spouse was the reason given for seeking admission by only 8 percent of the men but 30 percent of the women. These findings are consistent with the data from the Shanas study (Table 11) which show older males being more dependent than females for support from a spouse and older women being more dependent than males for assistance from a child. Brody's findings also suggest that the breakdown of the family care system may be related as much to conditions associated with the caregiver as with the care-recipient.

Conclusions for Policy and Research

- Public policy should be directed at alleviating the problems which interfere with the ability of families to care for their older relatives.
- Public efforts to address the problems associated with caregiving should recognize the diversity in the problems which exist as well as the differential effect the problems have on various types of caregiving situations.
- Any public policy directed at family caregiving should give special attention to the mental health problems affecting both dependent persons and their caregivers.
- More information is needed to identify the full range of problems associated with caregiving and the impact of such problems on the ablility to provide care, as well as on the well-being of both caregivers and care-recipients.
- The causes associated with the breakdown in family caregiving need to be more clearly identified. There is a particular need to develop a fuller understanding of the decision-making process related to institutionalization. Also, given the likelihood that a breakdown in family care can be traumatic for both the older person and his or her family, more attention should be given by researchers and policy-makers to the consequences of such breakdowns.
- Research should also be conducted to determine the extent to which the joint demands of work and caregiving affects either the quality of care or job performance.

[1]Brody, Elaine, "The Aging Family", Paper presented at the 19th Annual Meeting of the Gerontological Society, New York, 1966.

6. Family Caregiving and Formal Intervention

Major Findings:

- There is no conclusive evidence that the provision of formal care does or does not result in a substitution of family care. Preliminary data indicate however that in some cases families continue to remain actively involved in assisting their older relatives after the initiation of formal care.
- Some short term substitution of formal care for family care may be desirable from a public cost containment perspective. Such care may enable family members to maintain their older relatives in the community for a longer period of time than they might have otherwise in the absence of formal care.
- Family care appears to have a major influence on reducing the use of institutional care by older persons.
- The stated preferences of family members toward different forms of possible government assistance in caring for their older relatives indicate that no one method is best. A wide range of service and financial approaches have appeal to large numbers of caregivers. Evidence also indicates that the provision of formal services could enable significant numbers of families to keep their older relatives out of institutions.

Family Caregiving and Formal Care Utilization

A number of major policy documents have called for the provision of a variety of formal services to help families in the care of their elderly relatives. Before any large scale public investment is made in this area, however, policy makers will want to know if the provision of publicly financed services would merely result in the substitution of formal care for family care. Unfortunately there's insufficient evidence available at this time to draw definite conclusions on the issue, either one way or the other. It should be noted though that data do exist which indicate that outright substitution may not always occur.

The effect of formal care intervention on family caregiving was a subject of a study conducted by Cantor in 1979 titled "The Entry of the Formal Organization on the Informal Support Systems of Older Americans."[19] The sample for the study included 178 near-poor elderly persons receiving homemaker services from a formal agency in New York City.

Cantor found that the initiation of formal care for her sample of older persons already received help from a spouse or child resulted more in a shifting or redirecting of family care than in the withdrawal of such care. After the client began receiving the formal homemaker service, the percentage of family helpers decreased in the areas of personal care, and light and heavy housework. However, family care activity increased in the areas of meal preparation, shopping for groceries, traveling to the doctor, picking up the mail, help with finances and taking medication. (Chart 42)

Cantor's findings on the continuation of family caregiving in the presence of formal service provision is supported by other research. Preliminary data from a study in Massachusetts of 93 home care clients who received an average of 17.3 hours per week of paid help show that family members and other unpaid helpers were still giving an average of 46.6 hours a week of help, or almost three quarters of the total.[20]

The conceptual dimensions of the substitution issue were analyzed in a study by Urban Systems Research and Engineering, Inc.[21] The study concluded in part that some substitution of public for private care efforts may actually be desirable from a public cost containment perspective. Formal intervention in some cases could act as a form of relief for family caregivers and thereby enable them to extend the duration of their caregiving activity. In this respect, some substitution in the short run may serve as a public investment that yields long-run savings by delaying or preventing the use of more costly formal services, such as institutional or hospital care. However, the Urban Systems also concluded that only a longitudinal study could provide clear answers to many of the policy questions surrounding the substitution issue.

Affect of Family care on the Use of Formal Services

In addition to examining how the provision of formal care may or may not affect the demand for family caregiving, it is also important in the formulation of public policy to consider how family care affects the demand for formal services. Of particular importance here are the findings which show that the mere presence of a spouse appears to exert a dramatic influence on the use of institutional services. Data referenced earlier from the 1973-1974 National Nursing Home Survey demonstrate that married elderly at all ages have much lower rates of institutionalization than their unmarried counterparts. Previously noted data from Shanas also indicated a possible relationship between the presence of adult children and a decreased tendency by the elderly to reside in institutions.

It also appears that family caregivers might play a role in non-institutional formal service utilization patterns. Shanas found in her 1975 survey that older people with children, particularly those with children

[19]Cantor, Marjorie, "The Entry of the Formal Organization on the Informal Support Systems of Older Americans", AoA Grant No. 90-A-1329, Fordham University, New York, 1980.

[20]Sager, Alan, "Improving the Provision of Long-Term Care" in *Aging*, U.S. Dept. of Health and Human Services, March — April 1982.

[21]Urban Systems Research and Engineering, Inc., "In-Home Services and the Contribution of Kin," Cambridge, MA, 1982.

living in the same household, are more likely than persons without children to have seen a doctor recently, and less likely to say that they have not seen a doctor for more than a year. One explanation put forth in the Shanas study for this phenomenon was that adult children might in fact encourage an elderly parent with health complaints to see a doctor. To what extent such encouragement is preventive and therefore possibly cost-effective in nature is not known. (Chart 43)

The Massachusetts home care study referenced above offers a different perspective on the impact of family care on formal service utilization. This study found evidence which indicates that professionals tend to prescribe more episodes of help for a chronically ill older person than either the patient him/herself or the family. Equally interesting was the finding that caregivers consistently expected that unpaid providers could render a higher proportion of necessary services than those estimated by either professionals or patients.

Obviously, much more research will have to be conducted before we will be able to know the precise nature of the interaction that occurs between formal and informal caregiving.

Attitudes of Caregivers Toward Formal Intervention

Any attempt to develop programs of assistance for family caregivers should take into account the preferences of the intended recipients. Several studies have collected information of the attitudes of both current and potential caregivers for the elderly. Sussman was one of the first to examine this area in depth as part of his 1979 study "Social and Economic Supports and Family Environments for the Elderly".

The Sussman study was conducted in Winston-Salem with a sample consisting of three groups: 206 married persons between the ages of 21-64; 27 married persons in the same age range who were currently caring for a chronically ill older person, and 40 married individuals age 65 and older. Respondents were asked to rank the five following economic programs in order of their preference.

RENTAL OR PROPERTY TAX DEDUCTION — You would be able to deduct a portion of your rent or property tax based on how much space in your home is used by the older person.

FOOD STAMPS —You could buy food stamps for the older person and the family where the older person lives. This would allow you to buy food worth more money than the price of the stamps.

MONTHLY CHECK — You would get $200 to $400 each month to help pay for the expenses and extra time spent to care for your older relative.

TAX DEDUCTION — You could deduct up to $1500 from your income tax to cover expenses of caring for your older relative.

LOW COST HOME IMPROVEMENT LOAN —You could improve your home in order to take in an older person and pay a low rate in interest if borrowing money for home improvement was necessary. The government would then reimburse you up to 90% of the interest costs.

They were asked to do the same for the following service programs.

GENERAL SERVICES — This program would provide chore services (minor home repairs, heavy cleaning, yard and walk maintenance) meals on wheels, friendly visitors, telephone reassurance, escort service, shopping services and transportation.

MEDICAL CARE — This service would provide medical care to your older relative by either a doctor or nurse coming to the home if the older person were housebound, or transportation to a nearby medical center and subsequent care.

HOMEMAKER SERVICE — This would include housekeeping (light cleaning of house, light laundry, clothing repairs, ironing, etc.); homemaking (child care, money management, food planning, shopping, etc.); and personal care (bathing, dressing, feeding, grooming, hair washing and setting, medication, shaving, etc.).

COMMUNITY PLANNING AGENCY — A place to help families learn about available services for older relatives. It would help families get these service when needed and help solve some of the problems that could arise from providing care for an older relative.

SOCIAL CENTER — A place for the older person to do things with others away from the home. The center could also give care and/or supervision while you were away during the day. Transportation between home and the center and a hot meal also would be provided.

After ranking both sets of programs separately, respondents were asked to consider all the service and economic programs together and select the one they liked best. Sussman's findings were that medical care was the preferred service support while the monthly check was the preferred financial program. When all programs were considered together, the overwhelming majority chose the monthly check as most desirable, thus indicating a clear preference for the flexability of a financial incentive. However, within the group of 27 currently providing care, the greatest emphasis was placed on medical care and the social center, with only 11 percent of these people indicating a preference for the monthly check.

Sussman's overall sample is not a probability sample and therefore his findings are not general to a larger population. Nevertheless, additional insight is

provided on the relat . e desirability of these options by Horowitz.[22] In 1981, as part of her investigation titled "The Role of Families in Providing Long-Term Care to the Frail Elderly Living in the Community", Horowitz replicated Sussman's option questions. Her sample for this study consisted of 203 individuals identified as the primary caregiving relative to an older person receiving home or day care services in New York City. Sixty-five percent of the sample were adult children, 6 percent were spouses, with the remaining being other relatives.

Horowitz asked her respondents the same questions asked in the Sussman study. She did add one additional option to the list of service programs: a short-term center which was defined as a residential center where the relative could stay up to three weeks in order to give the family respite or time for vacation.

The patterns which emerged among the economic support options were generally consistent with those indentified in the Sussman study. The monthly check was ranked first by the largest number of respondents. There was slightly less consistency between the two studies in terms of the service preferences, with the Horowitz sample choosing homemaking services almost as frequently as medical care. (Chart 44)

The result of having the respondents consider all programs together is reported in Table 14. Of the total sample, 26 percent selected homemaking as the most preferred program, 25 percent selected medical care, 12 percent chose the social centers and only 10 percent identified the monthly check as the program liked best. A slightly different pattern emerged between spouses and children- spouses were much more likely to choose medical care and slightly more likely to choose a monthly check.

The general preference for services over financial assistance cited by Horowitz is consistent with that found by Sussman. However, since these studies did not use representative samples, this similarity can not be interpreted to mean that a significant number of family caregivers would not prefer nor benefit from some form of financial assistance. Of special note is the apparent underrepresentation of spouse caregivers in these samples - the group Cantor found to be more likely than other caregivers to experience financial strain.

Another perspective on the issue of assistance for family caregivers is provided by data from a national survey of Institutional Persons undertaken by the U.S. Bureau of the Census in 1976.[23] As part of this

TABLE 14: Percent Distribution of Program Selected as Most Desirable by Relationship of Respondent

Program	Total Sample (198)	Spouse (19)	Children (129)	Other Relative (50)
Homemaker	26.3	10.5	24.0	38.0
Medical Care	25.3	52.6	23.3	20.0
Social Center	12.1	.0	15.5	8.0
General Services	9.1	5.3	9.3	10.0
Community Planning Center	4.0	5.3	3.9	4.0
Short-Term Care Center	3.0	.0	3.9	2.0
(Service Sub-Total)	(79.8)	(73.7)	(79.9)	(82.0)
Monthly Check	10.1	15.8	9.3	10.0
Food Stamps	5.6	.0	7.0	4.0
Income Tax Deduction	1.5	5.3	.8	2.0
Rental or Property Tax Deduction	2.0	5.3	1.5	2.0
Low-Cost Housing Improvement Loan	1.0	.0	1.5	.0
(Economic Sub-Total)	(20.2)	(26.4)	(20.1)	(18.0)
Total	100.0	100.0	100.0	100.0

Source: Horowitz, Amy, "Social Economic Incentives for Family Caregivers", in *Financial Incentives for Informal Caregiving*, Community Council of Greater New York, (New York City) February, 1982.

[22] Horowitz, Amy, "Social and Economic Incentives for Family Caregivers", in *Financial incentives for Informal Caregiving*, Community Council of Greater New York, (New York City), 1982.

[23] "Survey of Institutionalized Persons", U.S. Bureau of Census, 1978.

survey, approximately 2,400 interviews were conducted with the next-of-kin of nursing home residents. Among other questions, these kin were asked to identify what services would have enabled the nursing home resident "to continue living in his residence rather than being institutionalized." The results are reported in Table 15.

TABLE 15: Responses by Relatives of Nursing Home Residents Concerning Necessary Services for Keeping the Patient at Home

Next-of-kin response	Services that would have enabled nursing home residents to remain at home rather than be institutionalized	
Food delivery service, such as Meals-on-Wheels	5.2%	
Housekeeping/shopping errands	6.5%	
Home health assistance, such as nursing or physical therapy	9.8%	
Day care assistance	7.6%	(Responses do not add to 100.0
Transportation	4.3%	because of multiple
Any other services	1.9%	answers)
None	82.0%	

Source: U.S. Bureau of Census 1978 a: Survey of Institutionalized Persons, (Question 6.).

Although the majority of cases responded that no service would have helped, 18 percent did state that services would have made a difference. Home health was the most frequently cited service followed by day care, housekeeping, food service, and transportation. This finding clearly has major significance for public policy, given the concern over the high cost of institutional care.

Conclusions for Policy and Research

- Policy makers should not assume that the provision of formal services to assist families in the care of their older relatives would necessarily result in a substitution of formal for informal care. Neither should policy makers assume that substitution of any kind would result in an overall increase in public costs.
- Much research is needed to determine the effect of formal care on family caregiving. In particular, a longitudinal study should be conducted to help resolve some of the major public policy questions in this area.
- A wide range of service and financial programs should be tested as possible vehicles for providing government assistance to family caregivers. It would be premature at this time to rule out any particular type of assistance, such as financial aid, as a possible form of government help to family caregivers. Further testing is needed before definitive conclusions are drawn in this area.

7. Future Demographic Trends

Major Findings

- The number and proportion of elderly will increase significantly in the future. Rates of growth, however, will vary considerably across decades and among different subgroups within the elderly population.
- The largest and most rapid overall growth will occur among the oldest of the elderly. Because of this, the number of impaired older people will increase dramitically and at a faster rate than the overall elderly population.
- While the overall burden of family care will probably not increase until after 2010, this may not be the case for various subgroups of the population. Evidence indicates that the family care burden posed by the elderly age 85 and over is already increasing and may continue to do so for the next 20 years.
- The projected increase in female labor force participation during the present decade may have a detrimental effect on family caregiving. It is impossible at this time to predict the long term consequence of female labor force participation on family caregiving due to the changing nature of work.
- It is unclear what overall effect, if any, future changes in the marital status of older people or divorce among their offspring will have on family caregiving. The projected increase in the proportion of elderly with four generation families does not appear to be of major significance.

Population Growth and Change

Projections on population trends can be developed through the use of various assumptions about the future behavior of key demographic variables. Not all of the assumptions may prove true and actual future states may differ from those anticipated. Nevertheless, the use of projections can provide decision-makers with important insights for policy planning purposes. The projections which are examined in this section are based mainly on Census Bureau and Social Security Administration data, and relate to trends occurring over the next seven decades that might affect family caregiving.

Projections on population growth by age are derived using estimates of the population already born and assumptions of future trends in such items as fertility, mortality, and net immigration rates. By 2030 the elderly population will be twice that of today while the total population of all age will increase by only 35 percent. As a result, the elderly will be a significantly larger portion of the overal population, rising from its current level of 11.2 percent of the total to 18.3 percent in 2030. This dramatic increase will be followed by a slight decrease to 17.6 percent by 2050. It is important to note that the increase in the propor-

tionate size of the elderly population will not occur at a constant rate. As Figure 3 shows, a moderate rate of growth will occur through 2010, after which truly dramatic increases take place. (Chart 45)

A look below the surface of this growth in the overall elderly population reveals some interesting dynamics. As Figure 4 shows, there is considerable variation in the pattern of growth taking place within this population. The three elderly subgroups comprised of people in the age ranges 65-74, 75-84, and 85+ all change over the next seven decades, but by different levels and at different times. The 75-84 and the 85+ groups will increase more rapidly than the 65-74 group between 1980 and 2010. The decades from 2010 to 2030 will see a reversal of this pattern, with growth in the 65-74 group surpassing that of the other two. From 2030 onwards, the pattern will again change, but this time the 65-74 group will actually decrease as a proportion of the total while the other two elderly groups continue to increase. (Chart 46)

Another way to examine the change projected in the elderly population is to examine the rates of growth which will occur for the three subgroups of the elderly. These rates are displayed in Figure 5. They provide a clear illustration of the different growth patterns within the elderly population. Comparison of the timing of the largest and smallest growth rates for the three subgroups exhibits an expected relationship. The 65-74 group experience its greatest increases during the 2010's the 75-84 group during the next decade (the 2020's) and the 85+ in the following decade (the 2030's). These are the decades when the "baby boom" generation becomes the "senior boom" generation. Similarly, consecutive decades of small growth are experienced by the three age groups in the 1990's, 2000's and 2010's when the small Depression era cohort reaches these ages and in the 2030's, and 2040's when the "baby bust" generation of the 1960's and 1970's becomes the "senior bust" generation.

It is obvious that the patterns of growth in the older population reflect to a large extent fluctuations in fertility. During any decade, the fertility rate helps determine both the proportionate size of the concurrent older population as well as the absolute size of a future elderly population. Different cohorts of women have different fertility rates.

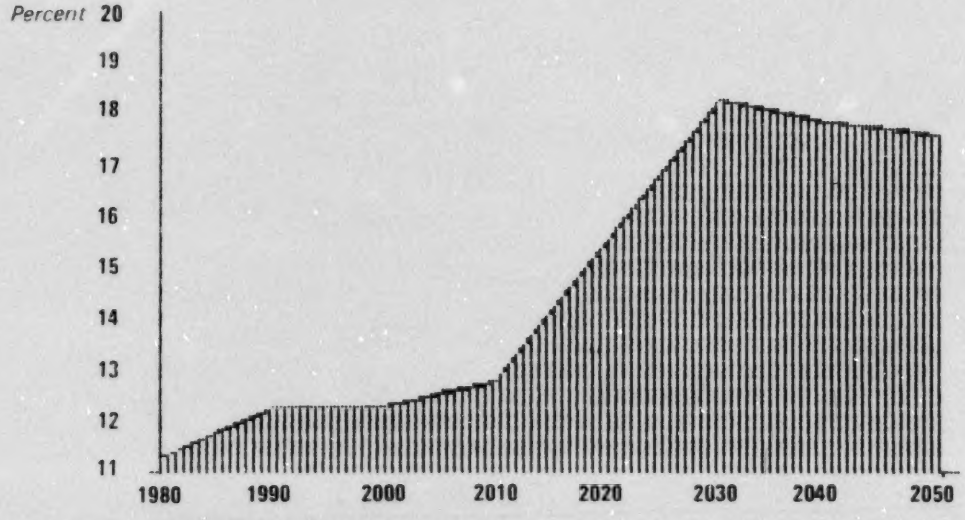
Those women born in 1905 who are now about 75 years old had an average of 2.4 children. These children were among the Depression babies. Those women born in the 1930's had more than 3 children on the average and produced the "baby boom" generation. The "baby boom" daughters in turn are expected to have fewer than 2 children each.* (Chart 47)

In addition to fertility, changes in life expectancy also exert a strong influence on the pattern of growth

FIGURE 3

Elderly Population As Percentage of Total Population

Projections 1980 – 2050

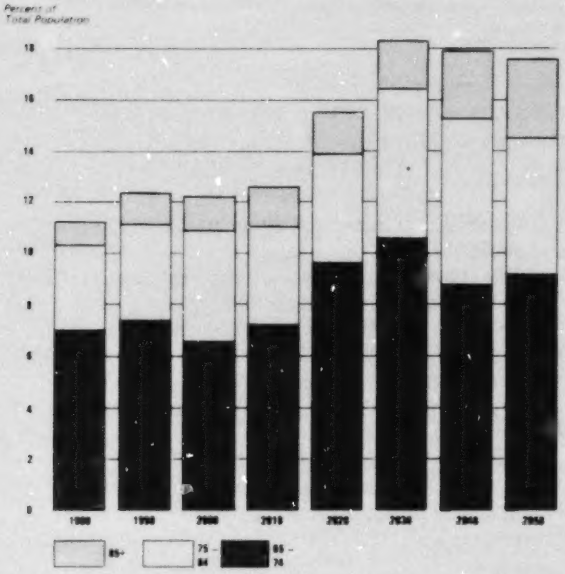


Source: New York State Office for the Aging, from data in the U. S. Bureau of the Census Publication, The Population of the United States: 1977 – 2050.

* The effect of these fluctuations in fertility on the number of offspring available to different elderly cohorts will be illustrated below in an examination of Dependency Ratios.

FIGURE 4

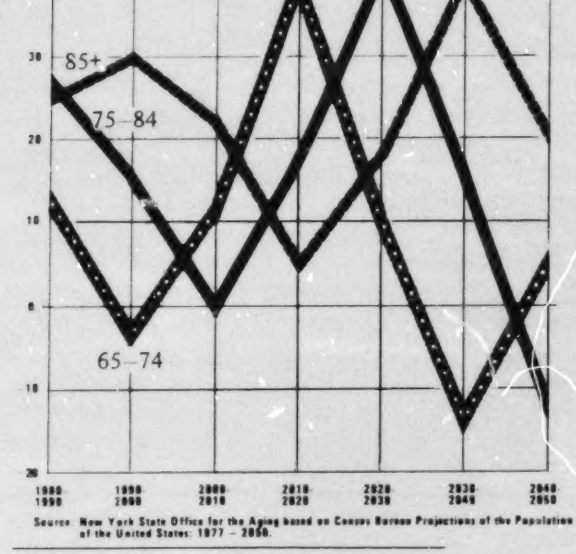
Elderly Population
As Percentages of Total Population
Different Age Groups, Projections 1980 – 2050



Source: New York State Office for the Aging, from data in the U.S. Bureau of the Census publication Projections of the Population of the United States: 1977 – 2050.

FIGURE 5

Projected Decade by Decade
Rates of Population Growth
of Various Elderly Groups



Source: New York State Office for the Aging based on Census Bureau Projections of the Population of the United States: 1977 – 2050.

in the older population. Life expectancy helps determine not only how many people will get to old age, but once there, how much longer they will live. Current projections of life expectancy at age 65 exhibit a constant increase for both men and women through 2050. Today's 65 year old man can expect to live almost to age 80; todays's women of age 65 can expect to live to 84. By 2050 the expected length of life will be over 82 for the 65 year old man and over 88 for the 65 year old women. This is why increasing proportions of the elderly will be reaching advanced ages in the future. (Chart 48)

Trends in Health Status

The extent to which older people will experience health impairments in the future will have an obvious effect on their need for family care. As would be expected, though, there is great controversy surrounding estimates on future states of impairments among the elderly. The general nature of this controversy is reflected in two schools of thought. On one hand, there are those who argue that future generations of the elderly will experience lower rates of impairment than those found in today's elderly due to improved life styles and higher socio-economic standards. On the other hand, many argue that while some improvements in health may occur, because of continuing increases in life expectancy, greater proportions of the elderly will be experiencing the chronic impairments associated with the later stages of life.[24]

While no one can be certain about the health status of the elderly in the future, is is nevertheless possible to develop projections in this area using certain assumptions. For purposes of this Report, dependency projections have been developed to provide a rough estimate of the number of older people who might be impaired due to a chronic health condition to the extent that they would require some type of assistance from others. They do not attempt to indicate any particular level of type of dependency other than being in need of at least a minimal amount of assistance. The basic assumption used in constructing the projections is that the application of current patterns of dependency in at least one ADL (Activity of Daily Living) to future elderly cohorts will provide some indication on the extent to which older people might be dependent on others in the future.

The ADL's include bathing, dressing, eating, and toileting. Data from the 1977 National Health Interview Survey report percentages of the elderly population unable to independently carry out one or more ADL. As expected, current patterns show that ADL dependency is much more prevalent among older groups of the elderly. While only 3.5 percent of the 65-74 age groups are ADL dependent, 11.3 percent of the 75-84 age group, and 35.1 percent of the 85+ group are. (Chart 49)

[24]For a more complete discussion of these two schools of thought see: Fries, J. F., "Aging, Natural Death and the Compression of Morbidity," in *The New England Journal of Medicine*, July 17, 1980, and Gruenberg, E. and Hagnell, O. (In Pres). "The Rising Prevalence of Chronic Brain Syndrome in the Elderly," in: L. Levi, A.R. Kagan (eds.), *Society, Stress and Disease*. London, Oxford University Press.

There are two major reasons for using current ADL patterns in constructing dependency projections. First, ADL measurements are currently recognized as acceptable measures of impairment and indicators of dependency among the elderly. Second, ADL measurements currently produce conservative estimates of the need for assistance and therefore projections based on ADL's should not exaggerate future states of dependence, even in light of some improvement in health status. The inability to carry out one or more ADL is a relatively serious condition and it is reasonable to assume that for many persons the threshold for needing some type of assistance from others is below the ADL threshold. As long as future gains in health do not increase the proportion of the elderly needing assistance beyond the proportions now marked by ADL dependency, the estimates should remain somewhat valid for policy planning purposes.

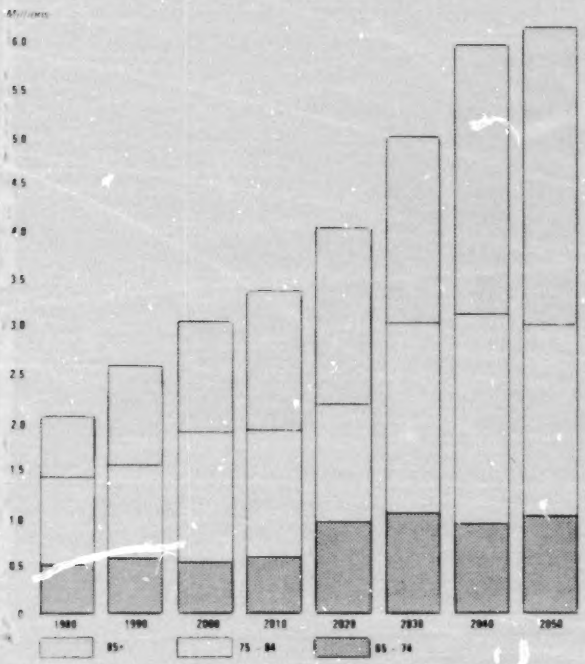
The projections on the total number of dependent elderly as well as the number of such individuals in different subgroups of the elderly population are displayed in Figure 6. As indicated, the overall number of elderly with some type of dependency will increase over the full 70 year period, from the 1980 figure of just over 2 million to more than 6 million in 2050. While the number of impaired persons with dependency in each age group increases significantly during the period, the 85+ group show the largest increase, from 800,000 to 3.3 million in 2050. This large increase reflects the concurrent largest increase in the total population of that age group.

Figure 7 compares the overall rate of growth projected for the elderly dependent population with that of the total number of elderly. A differential growth rate is apparent, with dependency showing a greater percentage increase over the next 70 years. By 2050 the numbers of elderly will have increased by 123 percent while the number of impaired dependent elderly will have increased by 192 percent. This pattern is the result of the large growth in population of the group most likely to have impaired members, the 85+ group. These different growth trends also illustrate the importance of using impairment rather than simply population numbers to indicate a possible change in need for support by the elderly in future years.

FIGURE 6

Dependency Among the Elderly

Projections for Different Age Groups 1980 – 2050

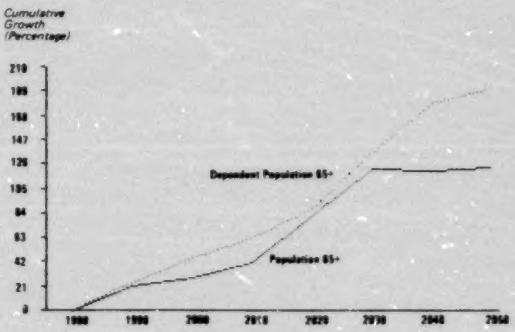


Note: Estimate of the number of older people who might be impaired due to a chronic health condition to the extent that they would require some type of assistance from others.

Source: New York State Office for the Aging, based on data from Bureau of the Census Projections of the Population of the United States, 1977 – 2050 and Health Care Financing Administration, Long Term Care, Background and Future Directions.

FIGURE 7

Cumulative Growth: 65+ Population and Dependent Elderly



Source: New York State Office for the Aging, from data in Bureau of the Census, Projections of the Population of the United States: 1977 – 2050 and Health Care Financing Administration, Long Term Care: Background and Future Directions

Dependency Ratios

Increases in the numbers of elderly and increases in the elderly as proportions of the population as well as the number who will be dependent on others for assistance give some indication of how the need for family support may grow. It is also important though to measure how changes in the elderly population compare to changes in that part of the population that provides support. "Dependency Ratios" help provide such a measure.

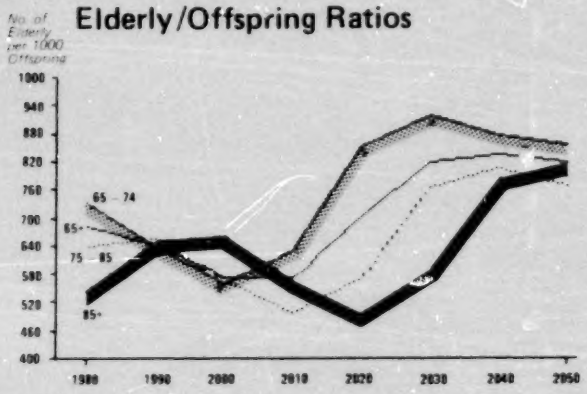
Two commonly used dependency ratios are the Aged Dependency Ratio and total Dependency Ratio. The Aged Dependency Ratio is defined as the ratio of the population aged 65 and older to the population aged 20 -64. The Total Dependency Ratio is the ratio of the 65+ population and the under 20 population to the working age population (aged 20 to 64). Aged Dependency Ratios are projected to increase slowly over the next thirty years, and then increase dramatically due to the aging of the baby boom generation.

Total Dependency Ratios display a different pattern because they factor in the shrinking younger age group. These ratios (comparing the working age population to the groups under 20 and over 65+ will continue their current decline that began around 1965. After reaching a low in 2010, they will turn upward again but will never reach the record levels of the 1960's when the "baby boom" generation was still young. (Chart 50)

For purposes of policy formulation on family care, the general concept embodied in dependency ratios can be refined to reflect changes occurring in the number of offspirng available to provide support to these elderly. Two additional dependency ratios have been constructed to achieve this level of refinement for this Report: an Elderly/Offspring Dependency Ratio and a Family Care Dependency Ratio.*

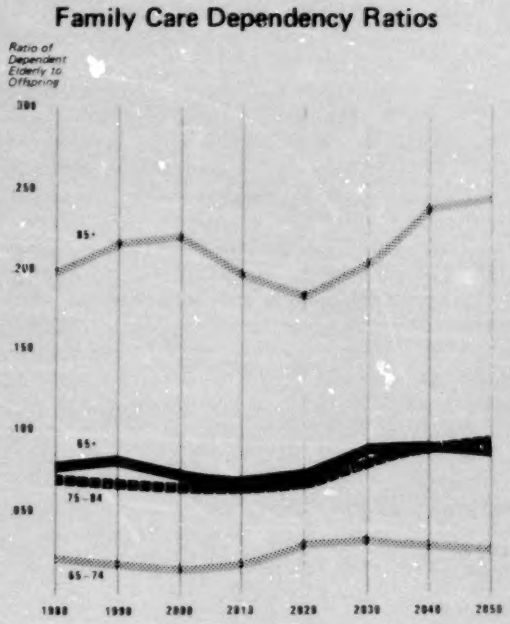
Elderly/Offspring Dependency Ratios compare the numbers of elderly to the numbers of younger people who are their offspring. Elderly/Offspring Ratios were developed for the total elderly population as well as for each separate elderly age group. Figure 8 displays these ratios which show up and down patterns for all elderly and for each individual subgroup. The ratios for all elderly, following a trend somewhat similar to that of the Aged Dependency Ratios, decreases from its current level of .680 (680 elderly to every 1000 offspring) to a low of .571 in 2000 and then rises to a high of .834 in 2040 before experiencing a moderate decrease. Again, this fluctuation largely reflects those periods when the baby boom generation are first the children of the elderly, followed by the period when they become elderly themselves. The ratios related to different age subgroups display somewhat different patterns, experiencing their highs and lows at different times. The 65-74 ratios decrease sharply to 2000 and then begin to rise, reaching a peak in 2030. The 75-84 ratio will initially, however, increase through 1990, before declining. The 75-84 ratios will reach their low in 2010 and then rise to a high point in 2040. The 85+ ratio will increase through 2000, before its initial decline. (Chart 51)

FIGURE 8



Source: New York State Office for the Aging: From data from Census Bureau and Social Security Adm.

FIGURE 9



Source: New York State Office for the Aging, from data from the Social Security Administration, Bureau of the Census and Health Care Financing Administration.

The Family Care Dependency Ratios are displayed in Figure 9. These ratios were developed using the previously cited dependency projections and measure changes in the number of elderly who might be dependent and in need of assistance with changes in the number of offspring for all elderly. Ratios were developed for all dependent elderly and for subgroups of the dependent elderly.

For the total dependent elderly population, the ratios remain fairly level over most of the period and then increase somewhat in 2030 and later. At the same time, however, more dramatic up and down patterns are occurring in both the 75-84 and 85+ groups. The ratios for 85+ group rises from its current level of .190 (190 dependent elderly for each 1000 offspring) to a level of .230 in 2000, then falls to .172 in 2020 and continues to rise thereafter, reaching a level of .286 in 2050. (Chart 52)

Both the Elderly/Offspring and Family Care dependency ratios suggest that even though the possible overall burden posed by all elderly and by all dependent elderly for their offspring will not increase until after 2010, and 2020, respectively, significant increases in this burden appear to be occurring now and are likely to continue to occur over the next two decades for the offspring of the elderly age 85 and over. The ratios also suggest that in relative terms, this group of dependent elderly 85 and over places a far greater burden on their offspring than other groups. The greater dispersion displayed among the Family Care Dependency Ratios as compared to the Elderly/Offspring Ratios is due to the higher levels of dependency in older age groups.

* For a description of the methodology used in developing these ratios, see Appendix D.

It is important to note the elderly age 85 and over are the elderly least likely to have a spouse available as a potential caregiver and therefore most likely to depend on their offspring for help. Also, the average age of the offspring of the 85 and over group is 60 years. Thus, many of the caregivers of the very old are facing the problems of age themselves. These two facts, coupled with the current growth in the overall dependency exhibited by the 85+ group in relation to their offspring clearly suggests that these people warrant special attention in the development of any policy directed at family caregiving.

Family Size and Structure

Study of trends in the family structure of the elderly enlarges upon the information that dependency ratios provided about the future relationship between those individuals who need individual support and those individuals who may provide this support. Since the primary providers of intensive support are the spouse and children of the older person, data related to spouses and children are the primary focus of this section. This data includes trends on marital status of the elderly, four generation families, and divorce among offspring of the elderly.

Marital Status of Elderly

Data on marital status of the elderly provides information on the numbers of elderly who have spouses who currently or potentially are available to provide support. Marital status projections are based on assumptiosn about future trends in such items as marriage rates, divorce rates and mortality rates. Over the next 60 years, while the absolute numbers increase dramatically, the proportions of total elderly who are married will remain fairly constant, averaging around one half. However, among older groups, slightly larger proportions will be married.

Between now and 2050, the proportion of individuals married in the age groups 75-84 and 85+ will increase 7.6 and 7.5 percent respectively. The effect of this change in the proportion of the very old who are married on family caregiving is unclear. On the one hand, it may increase the availability of spouses to provide care. The previously cited data on rates of institutional placement (Table 5) show that the presence of even very old spouses appears to be an effective deterrent to institutional placement. On the other hand, since it is likely that many of these spouses will themselves be very old and therefore possibly frail, this trend may also increase the number of older couples who are dependent on their children for support. (Chart 53)

Divorce Among Offspring

Future divorce rates among the offspring of the elderly have often been cited as a potential limiting factor for family caregiving. Data on the projected numbers of divorced individuals among the age groups in which offspring caregivers typically fall are shown in Table 16 and indicate only modest increases in the proportions of the offspring of the elderly who are divorced. Between now and 2040, the proportion of individuals who are divorced among the offspring of the elderly will only increase from 9 to 13 percent. However, there are variations among the offspring of different elderly groups which should be noted. For instance, the proportion of those divorced among the offspring of the elderly age 75 will increase from 10 percent to 15 percent over the next 10 years, and then begin to decline, ending at 13 percent in 2040. For the offspring of the elderly age 85, the proportion who are divorced will jump from 7 to 17 within the next two decades, and then decline by 5 percent the following decade.

TABLE 16: Divorce Among Offspring Age Groups, Projections 1980 to 2040

	Percentage Divorced in Age Group			
	35-64[a]	35-44[b]	45-54[c]	55-64[d]
1980	9	10	10	7
1990	13	12	15	14
2000	13	11	12	17
2020	13	14	14	12
2040	13	13	13	14

Source: New York State Office for the Aging, based on data from Social Security Administration, *Actuarial Study No. 84.*

[a] typical offspring of all elderly
[b] typical offspring of elderly age 65
[c] typical offspring of elderly age 75
[d] typical offspring of elderly age 85

What effect if any these divorce rates among the offspring of the future elderly will have on family care in unknown. There is no definitive evidence that divorce has any serious overall effect, one way or the other on family caregiving activity.

Four Generation Families

The increase in the number of four generation families has also been cited frequently as a factor relevant to family care, possibly contributing to an increase in the competitive demands placed on families having to support a larger number of members. However, although future trends indicate that the absolute number of four generation families will increase, there will be only a very slight increase in the proportion of elderly with great-grandchildren. Between now and 2050, the proportion is expected to rise slowly from 37% to a high of 40% in 2040 and then down to 39% in 2050. It seems unlikely these minimal percentage increases in four generation familes will exert a major influence on the overall state of family caregiving in the future. (Chart 54)

Female Labor Force Participation

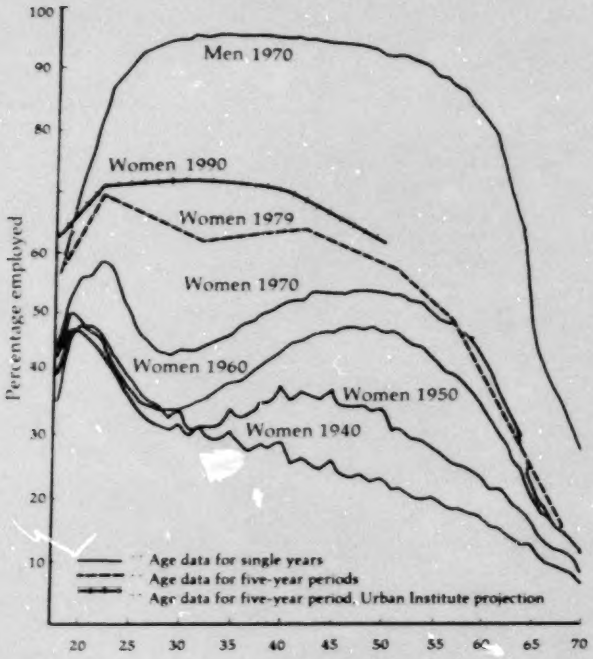
Labor force participation on the part of females is another factor that has been identified as a possible hindrance to the provision of family care in the future.

As previously noted, Soldo found that female labor force participation appears to increase the likelihood that a family will place their older relative in an institutional setting.

The Urban Institute has made projection through 1990 for women of different age groups through age 55. These projections are shown in Figure 10 and assume continuation of recent trends that have generally shown labor force participation to be increasing for women of all ages up through 55 and decreasing for near-elderly and elderly women. In 1979, the labor force participation rate was just under 65 percent for women age 35 to 44 and about 58 percent for women 45-54. By 1990, the respective labor force participation rates for these groups are projected to be 70 percent and 61 percent.

FIGURE 10

LABOR FORCE PARTICIPATION RATES FOR WOMEN BY AGE, 1940-1990



Source: George S. Masnick, *The Nation's Families: 1960-1990*, Boston, 1980.

Projections on female labor force participation are not readily available for years beyond 1990. Regardless of what the future levels of employment among females might be, though, it is simply impossible to predict at this time the effect of work on the future of family caregiving. The nature of the workplace and of work itself is expected to undergo fundamental change, mainly as a result of technology.[25]

Therefore, based on the employment projections which are available, in light of Soldo's findings, it does seem reasonable to assume that increases in employment among females during the present decade may exert a negative influence on family caregiving. Beyond 1990, however, any attempt to calculate the impact of family caregiving would involve pure speculation at this point.

Conclusions for Policy and Research

- The government should begin planning for a possible increase in the overall burden of family care in the future. In doing so, it should recognize that an increase might already be occurring in the family care burden posed by persons age 85 and over.
- Efforts to assist family caregiving should give special attention to those situations involving older persons age 85 and over because of the relatively large burden placed by people in this age group on their children and because of the age of their caregiving children.
- More research should be conducted on possible distributions of impairment among future elderly generations.
- More research should also be conducted on the possible effects of divorce among the offspring of the elderly on family caregiving.
- Research should be conducted to identify uses of technology in the workplace that will enhance the family caregiving capacity of employees.

8. Existing Policies and Programs

Major Findings

- Most of the major public programs which benefit the elderly were enacted prior to our current understanding about the important role played by family members in the care of older people.
- The living arrangements and economic status of family members can have a direct effect on an older person's eligibility and/or benefit level under some of our major public assistance programs.
- The extent to which family caregiving is either enhanced or deterred by the requirements and/or structure of our current benefit programs is unknown.
- A number of program initiatives have already been undertaken to assist families in caring for older relatives. However, the effect of these initiatives on either family caregiving or the well-being of the older person is not known at this time.

[25] For an extensive examination of the possible effects of technology on the future of work, see the series of articles on "The Mechanization of Work" in *Scientific American*, September 1982.

Existing Service and Entitlement Practices Toward the Elderly

Formal recognition of the needs and concerns of older people in our society is a relatively recent phenomenon. It was not even 50 years ago when the first major national social program designed to assist the elderly was launched with the enactment of Social Security in 1935. This effort to provide economic support to the elderly was expanded in 1965 with the passage of the Medicare Program to help insure older people against the potentially devastating burden of health care cost. Two other major social initiatives for older people were also created in 1965: Medicaid and the Older Americans Act. Medicaid provided funds to guarantee the availability of health care to the poor, including the elderly poor. The Older Americans Act was enacted to improve the coordinated delivery of social services for the elderly in order to prevent unnecessary institutionalization. Finally, in 1974, the Supplemental Security Income Program was enacted to provide a minimum guaranteed income for the elderly poor as well as the blind and disabled.

The possible failure of family members to contribute their "fair share" to the cost of caring for their older relatives has become an issue of major interest to many public officials, especially in light of the continuing rapid growth in public health care expenditures. There have been calls for the enactment of laws to expand the legal responsibility family members have for their older relatives. However, there is no clear evidence that families in general have or have not reduced their caregiving efforts as a result of our existing benefit and service program. Nevertheless, it should be pointed out that the information cited in a previous section of this Report on the value of family care suggest that families are currently contributing a great deal — possibly as much as they can — to the care of their older relatives. Also, a recent analysis of the imposition of federal requirements on adult children to increase their contribution to the care of their elderly relatives under the Medicaid program indicates that little may be gained in public savings by such action.[20]

The other concern raised by the fact that our public programs may not be giving adequate consideration to family caregiving relates to the possible negative effects some of these programs may be having on those families who are trying their best to care for their elderly relatives. Specifically, it has been argued that many of our public programs contain provisions which act to increase the burden of family caregiving. The one-third reduction in SSI benefits for older persons living with a relative is perhaps the most often cited example in this area.

Unfortunately, as with the first concern, there is simply no body of empirical evidence which can be used to substantiate whether or not our existing benefit programs exert any significant influence — either positive or negative — on family caregiving. This does not mean that such influences do not exist. It only means that more information on the effects of these programs must be generated before we can be certain that unintended negative consequences are not resulting from our public efforts to help the elderly.

A first step towards determining the impact of our programs on family caregiving is the identification of how benefits to the elderly are affected by their family situation. The following descriptions attempt to contribute to this needed information base. For each program, the description identifies how eligibility and benefits are generally affected by either 1) the fact that a family member is living in the same household as the older person, and/or 2) the income or assets of family members. The review covers the major entitlement programs which benefit the elderly and is limited to provisions stipulated in federal statute and regulation, as of July 1982.

Social Security

Social Security (OASDI) is a compulsory retirement and disability insurance into which all wage earners must pay in order to receive benefit payments at retirement age. Payment levels are based mainly on the level of income during the working years of the individual, or the individual's spouse or parent, and the age at which the individual begins receiving payments.

Once established, the benefit level for an individual will not change except for cost of living increases, deductions for excess earnings or a change from spousal benefits to widows benefits. Individuals may take advantage of the benefits of living with others for comfort, companionship, care or economics of scale without affecting their own benefit level. (42 USC §401ff, esp §402, 403).

It should be noted that having a spouse, whether or not the spouse lives in the same household, can affect Social Security benefit levels. A wage earner and his/her nonworking spouse receive a benefit that is one-and-one-half times that received by a single wage earner. A widow or widower of a wage earner receives a benefit even if he or she never worked. If both spouses have worked, each spouse receives his/her own benefit or one-half of the spouse's benefit whichever is higher. Providing full-time care for an elderly relative can lower the level of Social Security benefits that a caregiver will ultimately receive. Time away from paid employment will result in the accumulation of fewer Social Security earnings credits and the consequent lower benefits based on the caregiver's earnings record.

[20] Callahan, et. al., "Responsibility of Families for Their Severely Disabled Elders," *Health Care Financing Review*, U.S. HHS, Volume 1, No. 3, Winter 1980.

Supplemental Security Income

Supplemental Security Income (SSI) is a needs based program of income supplementation which sets a level of income which the Congress has determined is necessary for aged (65+), blind, and disabled individuals to meet their needs of daily living. In addition to being aged (65+), blind or disabled, an individual must also have income and resources below that set by Congress to be eligible for this income supplementation. Certain resources considered reasonable and necessary, such as a home, life insurance, auto, etc., and some earned and unearned income are excluded in determining resource and income actually available for purposes of eligibility. (42 USC §1381-1383C)

The payment of SSI consists of a federal amount, uniform in all states, and a state supplement which varies from state to state. If an individual or couple who otherwise qualifies for a SSI payment takes up residence with another, his/her/their state payment amount may be reduced (in New York State it *will* be reduced). If that individual or couple lives with others and receives some amount of food and shelter free from the other, his/her/their federal payment *will* be reduced by one third. (42 USC §1383C)

In all states except Arizona people eligible for SSI payment in any amount including state payment only — that is, their available income is less than the combined federal and state payment — are eligible for Medicaid (42 USC §1383C). In addition, if an individual is aged (65+), blind, or disabled, he/she can qualify for Medicaid in most states if his/her medical expenses reduce available income below state set medical or public assistance levels. (45 CFR §345.800)

Medicaid

Medicaid is a program of medical assistance to individuals and families who are poor. Medicaid provides necessary health care in a home, outpatient or institutional setting to individuals who meet the income and resource eligibility levels. (42 USC §1396d).

Since spouses are determined by the federal medicaid program to bear some responsibility for each other's care, the federal law considers that spouses living together have access to their combined incomes and resources. If they live together neither will be eligible for Medicaid unless their combined income and assets fall below state set medical assistance levels regardless of whether those resources are actually available. (42 CFR §435.821)

If the spouses do not live together, e.g., one spouse is institutionalized, and only that one needs medical assistance, their eligibility will be determined on the basis of their own assets and income and whatever amount of the spouses assets and income are actually contributed to them. (45 CFR §435.822, 831, 832, 840)

For example, if a husband and wife live together and have joint assets and income of twice the amount of the state medical assistance level neither can qualify for assistance. If the wife becomes ill and requires extensive home care they will receive medical assistance for the home care only after they expend an amount equal to the difference between their combined income and resources and the medical assistance level for a couple.

If, on the other hand the wife enters a nursing home to receive the necessary care under federal law, the couple only need spend the portion of their combined assets which are the property of the wife on her medical care for her to become eligible for medical assistance coverage of her health care needs. This fact will certainly affect any decision she must make regarding where she will receive health care. (45 CFR § 435.822)

Under most state laws the spouse in the community will bear some responsibility for contributing to the cost of the institutionalized spouse's care but her eligibility for medicaid is a separate issue and the contribution will certainly be less than were she to remain at home.

Under the same circumstances, were the ill individual not to have a spouse, she could receive her care in the home of another, perhaps a son or daughter or any other person, without the presence of the others in the household having an effect on her eligibility for medical assistance. This is because, under federal law, only the income and resources of a resident spouse would be counted in determining her eligibility, not that of other individuals unless it was actually made available to her. These others have no legal obligation to provide for her care. (45 CFR §435.712 (b))

In summary, then, the medicaid program distinguishes for purposes of eligibility between those individuals who live alone, those who live with a spouse and those who live with any other non-responsible relative or friend.

Medicare

Medicare is a federal program of health insurance which covers some expenses for hospital care, doctors bills and some very little amount of skilled nursing home care and skilled nursing care in the home. It is an adjunct of the Social Security program and eligibility for coverage is established essentially in the same manner as for Social Security (OASDI) benefits. Generally, those who qualify for Social Security will be covered by Medicare or may buy into the system with any other health insurance plan. Since there are no income or resource eligibility tests and benefits are paid on the basis of reasonable and necessary medical expenses, the fact that a beneficiary lives or does not live with any others, or has access to the financial resources of others, will have no effect on the amount or type of benefit for which he or she is eligible.

Food Stamps

The Food Stamp Program is a federal program enacted to promote the general welfare and to safe-

guard the well-being and health of the nation by raising the levels of nutrition among low income households. (Agriculture, 7 USC, §2011). This program is a needs-based program. Benefit levels vary according to the size of the household and the individual's income.

The definition of a household specifies that it consists of persons who live together in a non-institutional setting and who customarily purchase food and prepare meals for home consumption. Parents and children living together are automatically considered one household except if the parent is 60 or above or is disabled. (A boarder cannot get food stamps as a household separate from others in the home.) Although the program limits student eligibility, individuals 60 or over are exempt from student classification.

The resource limit for normal households, no matter how many individuals in the household, is $1,500 unless the household includes two or more persons, one of whom is an elderly or disabled person, in which case the resource limit is $3,000.

A household with an elderly or disabled individual may, unlike a regular household, deduct the amount of unreimbursed monthly expenses in excess of $35 from the calculation of monthly household income. Also, such households do not have a ceiling on their shelter deduction. All these factors affect the level of deductions. Also, households with elderly or disabled are given a lower maximum income level to qualify for food stamps in that their level of eligibility is computed as the net income (after allowable deductions) at 100% of poverty as compared to all others whose income is computed at gross income (before deductions) at 130% of poverty.

It appears that unless an elderly individual were eligible for Food Stamps mainly on the basis of excess shelter costs which would be alleviated by moving into the household of relatives (informal caregivers), there would be no disadvantage to such an action either to the caretaker family or the elderly individual.

Current Program Initiatives on Informal Supports

There are a number of programs and demonstration projects now being operated throughout the country in response to a growing recognition of the role played by informal supports, including family members, in the care of the elderly. Except for some large projects in states like California and Florida, most programs are small in scale. The demonstrations generally are funded through federal grants, although other sources of funding are being utilized.

Evaluation data on some of these programs is available to a limited extent. Overall, however, insufficient information exists at this time to draw definitive conclusions about the impact of any of these programs on either family caregivers or the well-being of older people. Some of the programs may be providing substantial benefits to family caregiving units, but information on such benefits has not been compiled yet that would enable policy makers to make sound resource allocation decisions.

The following descriptions provide an illustrative list of current initiatives on informal supports. These programs are classified under the broad categories of education, financial assistance, and services. It should be noted that a number of additional programs may also be in operation throughout the country. Without some type of national clearinghouse for information on family caregiving, though, it is practically impossible at this time to compile a complete listing of relevant activity in this area.

Education

Educational strategies have been developed primarily to bolster and develop the caregiving capacity of informal supports to meet the needs of the frail elderly. Two nationally recognized model projects which provide education to informal caregivers are: The Natural Supports Program developed by the Community Service Society in New York City, and the As Parents Grow Older program which is jointly sponsored by the Institute of Gerontology at the University of Michigan and the Children and Family Services of Michigan, Inc. Both programs aim to support informal care providers by offering informa- education, and emotional support.

The Natural Supports Program utilizes two group modalities: large community-wide, socio-educational group meetings and smaller, socio-educational peer support groups. The groups are coordinated by trained group facilitators, with a self-help model promoted for groups which plan to meet on a long-term basis. The group experience offers skill training, education, and peer support to care-providers and persons anticipating the caregiving role.[27]

The As Parents Grow Older (APGO) model integrates the educational with the therapeutic in a structured program approach. The model entails six group sessions for 12-14 participants. For each of the six sessions a discrete curricula has been designed. The educational materials are presented by two co-facilitators who have been specially trained on how to run APGO groups. In addition to conducting the educational component, the group leaders function to promote communication and peer support within the group.[28]

The Jamaica Service Program for Older Adults in New York City developed a Caregivers Training Program which was funded in part by grants from the Ittleson and Public Welfare Foundations. The curricula called for an eight week training course designed to provide those who care for older adults who are mentally, emotionally and/or physically frail with the

[27] Holmes, D., "Case Studies of Programs Which Provide Services to the Informal Supports of the Elderly", Community Research Applications, Inc., April 1981, New York, NY, AoA Grant 90-AR-2106.

[28] Ibid.

information, skills and attitudes necessary to be responsive and effective caregivers. To date 95 trainees have successfully completed the course, and it has been estimated that approximately 1800 impaired elderly persons have received care from those trained through the project.[29]

A model training curriculum for Informal Caregivers entitled, "Practical Help for Those Caring for an Elderly Person," was developed by the New York State Office for the Aging in 1982. In seeking avenues for widespread dissemination of the curriculum SOFA, in cooperation with the State Education Department, focused on providing the training program through the system of Adult Education programs in local communities across New York State. The curriculum is also being made available to Informal Caregivers through various senior centers, college campuses, church groups and other local community organizations, etc. This document is a replicable resource for training those who are presently informal caregivers, or expect to be in the near future. In addition, it can be offered as a resource to the elderly themselves in order to increase their personal understanding of ther aging process, or it can be used as a refresher course for agency personnel, such as home health aides. Its module format makes it adaptable to workshop settings or a sequential course offering in six sessions. Overall objectives of the program include helping participants increase their understanding and knowledge of the aging process; better understand the emotional reactions and needs of older people; and learn to deal more effectively with their own needs. Strong emphasis is placed on imparting personal care skills and knowledge of community service resources.

Financial Assistance

Recommendations to enhance the role of informal caregivers through the provision of financial assistance have been present in the literature for some time. Several major projects have been undertaken to explore the nature of the impact of financial assistance on the actual provision of informal care. Projects in Maryland, Florida, and California are of particular note in overviewing efforts focused on the provision of assistance to informal caregivers.

The Maryland State Office for the Aging undertook the Family Support Demonstration Project in October 1979. The two-year study involved making monthly payments based on income to families of the impaired elderly. The agency relied upon State funds to conduct the project which is geared towards testing specific methods of supporting and strengthening informal supports.

Participation in the Maryland project was based upon the selection of a number of families currently caring for elderly members at risk of institutionalization. One half of the families received monthly grants up to a maximum of $2000 per year based on the elderly person's income and assets. The other half of the families acted as a control group and were paid $25 for their record-keeping activities. Both groups were required to keep records of the cost of caring for the elderly member. Through the use of pre and post tests, the Maryland Office for the Aging hopes to determine the overall impact of financial assistance. This impact will be measured by changes in the caregiver's morale and coping ability scores as well as by changes in the recipient's functional assessment and morale. Key variables to be explored include the caregiver's willingness to care for the impaired individual, caregiver morale, functional health of the elderly person, and the frequency of crisis admission of the elderly person to a health facility. While preliminary reports presented data detailing cost of home care, and the initial testing of the elderly and their caregivers, data on the effectiveness of the grants is not yet available.[30]

Florida's Home Care for the Elderly Program was started in 1977 to encourage provision of care for the elderly residing in family type living arrangements in private homes. The program entails a schedule of subsidy payments which are funded by the State. There are two payments, one for both basic support and maintenance and the other for health care when not covered by Medicare, Medicaid, or insurance. Although the program is not specifically limited to relatives of eligible elderly persons, in most cases (95%) subsidy payments are made to relatives caring for family members. Proof of expenditure is required for health care payments, but basic support subsidies are paid to caregivers without such evidence.

Applicants for the Florida program must fulfill certain financial eligibility conditions in addition to having a caretaker willing to provide maintenance and support services. Financial eligibility is based upon the same criteria established for Florida's Title XIX Institutional Care Program. In 1980 the program was providing caregivers of 1424 elderly, with highest priority given to applicants facing immediate placement in nursing homes or state institutions. The average monthly home care payment is $139, compared to $421 for the State's share in a skilled nursing care facility.[31]

California's In-Home Service (IHS) Program provides among other benefits, payments to individuals, including informal care providers, for specified services rendered to eligible program recipients who choose to live in their own homes. Funding for the program originated from a mix of federal, state and local sources. Eligibility for services is limited to those who are eligible for California's SSI Program and who need IHS in order to maintain an independent living arrangement in their home. A needs assessment is performed by the County welfare Department which

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Jamaica Service Program for Older Adults, *Guidelines for Caregivers of the Frail Elderly*, New York, NY, 1982.

Whitfield, S., "Family Support Demonstration Program", in *Financial Incentives for Informal Caregiving*, Snyder, C. (ed.), Community Council of Greater New York, October, 1981, New York, NY.

New York State Office for the Aging "Financial Incentives and Informal Supports for the Elderly: A Review of Current Research and Program Efforts," March 1981.

determines the type and amount of services required including homemaking and personal care services. The individual can then obtain the specified services from a provider, including a family member, and the provider will be paid at the hourly rate set by the county. In April 1980, 55.5% of the providers were friends or relatives. The program serves 97,000 clients, of which almost 60% are elderly.

Through the California program, total payment for services for any one individual is limited by a maximum monthly amount that depends on the degree of disability. In 1980 those who were "severely" impaired (with a total assessed need for twenty hours or more per week of service in activities such as personal care and meal preparation) were limited to $767 per month and those "not severely impaired" were limited to payment of $532. In 1980 the average monthly payment was about $200. The total annual cost of the program is about $250 million. Under the program clients receive an average of 55 hours of care each month. As of 1981, no systematic study had been conducted on the extent, if any, to which payments to family members and friends of program recipients has affected the caregiving behavior of informal supports.[32]

Services

Service projects range from local self-help groups to nationwide demonstrations. Such programs usually relate to a perceived need to expand and/or enhance the accessibility of formal community supports such as adult day services, respite care, home-delivered meals, case management and home care.

Mutual Help for Community Elderly was operated as a model project during a 17-month period, February 1977 — June 1978 by Southern Illinois University at Benton. The program utilized a mutual help model to organize small social groups within neighborhoods to serve as units through which peer outreach and support could be planned and conducted. Project participants were 60 years of age or over with a mean age of 73.9 years. All clients were white, and no income requirement was utilized. Of the 202 participants, 45% were married and 79% had living children.

There were two components to the Benton program: the development of mutual help networks and direct service provision within the context of a Title III multipurpose center. The development of informal and mutual support networks took place within the small group neighborhood meetings. As of 1981 there were 10 groups underway, with meetings held every 2 weeks and attendance averaging 20 persons per group. The content of the meetings included recreation, planning of events, activities and parties and planning and coordinating helping activities to elderly persons who are known to be in need of assistance.

An evaluation of the Benton program included pre and post-program surveys of participants (N=202) and non-participants (N=98) in Benton, of residents of Harrisburg, a control town. (N=74), of staffs of local agencies (N=37), and of long-term care institutions in Benton and Harrisburg. Results of the evaluation indicated that after the demonstration period, the Benton participants "made more new friends than the control groups ... and visited more frequently than elderly in the control community". With regard to measurement of individual integration with formal community networks, Benton participants scored significantly higher than the controls on "having a say in community concerns and number of new organizations joined in the last two years." The evaluation also showed that long-term care admission rates for the population 55+ actually decreased from 38% to 27% in Benton during the evaluation period, and increased from 21% to 27% in Harrisburg (control community) during the same period. Although no direct link can be made between this decrease in institutionalization and the Benton project, the need for further investigation into this phenomenon is apparent.[33]

In 1981, the New York State Legislature authorized the establishment of several respite demonstration projects throughout the State under the auspice of the NYS Department of Social Services. This effort is designed to encourage the initiation and expansion of respite care, evaluate the effectiveness of respite in deterring institutionalization, evaluate the demand for respite and to ascertain the most appropriate service for various levels of disability and dysfunction and the cost and utilization of a variety of service modes, and of their coordination.

In the legislation, respite is degined as the "provision of infrequent and temporary substitute care or supervision of frail or disabled adults on behalf of and in the absence of the caregiver". Respite must be at least twenty-four consecutive hours but not more than six weeks in any calendar year. A wide variety of providers and modes of delivery are encouraged by the legislation. The law encourages flexible and creative use of existing local resources and the use of existing reimbursement services as well as payment by the client and/or the family. Priority is given to frail or disabled adults, sixty years of age or older. Several NYS respite demonstrations are already underway; however it is too soon to procure any evaluatory information on the projects.[34]

Finally, in an effort to examine the broad area of informal support and public policy, the Governor's Health Advisory Council in New York State formed a Steering Committee on Informal Support Networks in September, 1980. The Committee was comprised of Health Advisory Council members, researchers and academicians in the field of gerontology, government policy makers and voluntary sector representa-

[32] Ibid.
[33] Holmes, D., "Case Studies of Programs Which Provide Services to the Informal Supports of the Elderly".
[34] Chapter 767, Laws of New York State, 1981.

tives. The Committee identified and addressed several major policy questions, and proposed strategies to promote a comprehensive approach to enhancing and sustaining informal supports. As part of their effort, the Council sponsored a Conference on Informal Support Networks in Saratoga, New York in April, 1981. The purpose of this Conference was to build an agenda of strategies that could be carried out through various groups and agencies in New York State. Four areas were used as the focal points for the discussions, and the development of recommendations at the Conference: 1) training for caregivers and for the formal service system, 2) service strategies, 3) economic supports, and 4) housing options. The scope of the discussion included caregivers for all age groups, not just the elderly. Overall, a number of specific strategies were identified to foster government support for informal caregiving.[35]

Conclusions for Policy and Research

- More research needs to be conducted to determine the effects, either positive or negative, that existing entitlement and benefit programs have on family caregiving.
- Research is also needed to determine the most effective method of assisting families in providing care to their older members. Specific consideration should be given to determining the effect different program methods have on both family caregivers and older care-recipients. Any publicly financed program directed at family caregivers should include an evaluation component.
- A National Clearinghouse should be established to assist in the coordination of research on family caregiving and in the dissemination of findings.

[35] New York State Health Advisory Council, "Enhancing and Sustaining Informal Support Networks for the Elderly and Disabled: Conference Proceedings, November, 1981.

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Appendix A
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CHART 1: Number of Surviving Children, Persons Aged 65 and Over With Children in 1975 (Percentage Distribution)

Number of Surviving Children	Percentage of Elderly (with children)
1	25
2	26
3	17
4	13
5	6
6	5
7 or more	8

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 2: Living Arrangements of Parents, Persons Aged 65 and Over With Surviving Parents, by Sex of Parent: 1975[a] (Percentage Distribution)

Living Arrangements of Parents	1975 Mother	Father
Living alone or with spouse	24	c
Living with respondent	23	c
Living with other children	24	c
Living with other relatives	6	c
Living in nursing home	18	c
Living in home for aged	4	c
Other living arrangement	2	c
Total	100	c
N (weighted) =	(198)[b]	(40)

[a] The percentage of the total sample with surviving parents is 4. Some 3% had a surviving mother only; less than 1% had a surviving father only; and less than 1% had both parents alive.

[b] The percentage of eligible respondents who answered this question is 96.6.

[c] Percentages not computed on a base less than 50.

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 4: Percentage Distribution of the Need for Assistance Scale (NAS) for Elderly Persons by Age and Sex: 1976 SIE

Age and Sex		NAS Levels: No Assistance Needed	Minimal Assistance Needed	Moderate Assistance Needed	Extensive Assistance Needed	Total
65-69	males	95	1	1	3	100%
	females	94	2	2	2	100%
70-74	males	95	1	1	3	100%
	females	91	2	3	4	100%
75-79	males	91	2	2	5	100%
	females	86	3	5	6	100%
80-84	males	84	3	3	9	100%
	females	77	5	8	10	100%
85+	males	75	4	4	17	100%
	females	61	6	12	21	100%
All ages	males	92	1.5	1.5	8	100%
	females	87	3	4	6	100%

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01

CHART 3: Living Arrangements, Unmarried Persons Aged 65 and Over, by Age and Sex, 1975[a] (Percentage Distribution)

	Men					Women					*All*				
Living Arrangements[b]	**65-69**	**70-74**	**75-79**	**80+**	**All**	**65-69**	**70-74**	**75-79**	**80+**	**All**	**65-69**	**70-74**	**75-79**	**80+**	**All**
Living Alone	75	63	62	56	65	69	69	70	60	67	70	68	68	59	66
Living with married child	4	11	8	10	8	4	5	8	12	7	4	6	8	12	7
Living with unmarried child	6	7	4	9	6	7	11	9	19	11	7	10	8	17	10
Living with other	16	19	26	25	21	20	15	14	10	15	19	16	17	12	16
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
N (weighted) =	(173)	(156)	(122)	(109)	(560)	(607)	(591)	(435)	(558)	(2191)	(780)	(747)	(557)	(668)	(2751)

[a] Includes widowed, separated, divorced, and never married persons.

[b] This is a priority code. When more than one living arrangement was mentioned, the priority for coding used is the same as the order of the categories in the table; for example, when living with married child was mentioned in combination with any other living arrangements, the response was coded under living with married child.

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 5: Percentage Distribution of the Need for Assistance Scale (NAS) for Elderly Persons by Sex and Marital Status: 1976 SIE

Marital Status and Sex		NAS Levels: No Assistance Needed	Minimal Assistance Needed	Moderate Assistance Needed	Extensive Assistance Needed	Total
Married	male	93	1	1	4	100.0%
	female	92	2	2	4	100.0%
Widowed	male	89	2	2	6	100.0%
	female	83	4	6	7	100.0%
Separated/ Divorced	male	90	2.5	2.5	5	100.0%
	female	89	4	4	4	100.0%
Single	male	93	2	1	5	100.0%
	female	89	3	3	5	100.0%

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

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CHART 7: The Relationship Between Personal Time Dependency (PTD) and Indices of Psychiatric, Medical and Social Conditions (Mean Scores on Rational Scales)

	Levels of Dependence: Independent N=313	Dependent N=132	Limited Home Care N=44	Adult Home N=45	Nursing Home N=43
Possible Causes					
Dementia	.65	2.57*	1.40	2.02	4.35*
Arthritis	1.88	2.35**	2.11	2.64	2.28
Heart	.59	1.03*	.79	1.22	1.07*
Neurological	.01	.23*	.14	.18	.37*
Physical	4.23	7.18*	5.52	7.35	8.72*
Immobility	.81	7.12*	3.86	7.35	10.20*
Perceptual	1.05	2.66*	2.52	2.66	2.79*
Possible Effects					
Depression	2.58	4.70*	4.11	4.31	5.72*
Inadequate Activ.	2.80	6.23*	4.68	6.44	7.58*
Current Isolation[1]	5.13	4.51*	4.56	5.04	3.90*
Possible Disadvantages					
Financial	.62	1.05*	.75	1.28	1.12
Crime	.74	.65	.93	.62	.40
Environment	2.46	2.95	2.93	3.20	2.70

F ratio for one way analysis of variance showed significant differences in mean scores

* F ratio significant, $p < .01$
** F ratio significant, $p < .05$
[1] Low score means high isolation

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 6: Percentage of Persons Aged 65 and Over Reporting Income and in the Lowest Income Quartile by Incapacity Scores[a]

Year	Percent in Lowest Income Quartile Incapacity Scores			
	0-2	3-4	5-6	7 or more
1962				
Percent	23	32	42	47
N=[b]	(1884)	(168)	(86)	(85)
1975				
Percent	22	34	44	63
N=[b]	(3715)	(266)	(198)	(65)

[a] Excludes bedfast persons; excludes persons whose spouses gave fiscal data.

[b] The N (number) of cases for 1962 is unweighted; the number of cases for 1975 is weighted. For 1962, 49 married couples, 7 unmarried men, and 67 unmarried women with income did not report the amount of income and are excluded from the quartile distribution. Also excluded are 64 married couples where the wife was interviewed but the man either was under 65 years of age or was not interviewed because of illness, deafness or language problems. For 1975, 183 (weighted) married couples, 20 (weighted) unmarried men and 217 (weighted) unmarried women with income did not report amount of income and are excluded from the quartile distribution. For 1975, the percentage of eligible respondents who answered these questions is 91.1.

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 8: Demographic Characteristics of Persons with Personal Time Dependency

Characteristics	Independent 70% (N=313)	Dependent 30% (N=132)	Total 100% (N=445)
	Percent of Cases		
Marital Status			
Never married	87	13	100 (N= 31)
Divorced and Separated	82	18	100 (N= 22)
Widowed	64	36	100 (N=179)
Married	75	25	100 (N=204)
Unknown (N-9)			
$X^2 = 11.73$, $p = < 0.01$			
Living Arrangements			
Lives alone	75	25	100 (N=135)
Lives with others	69	31	100 (N=289)
Unknown (N=21)			
$X^2 = 31.38$, $p = < 0.01$			
Sex			
Male	76	24	100 (N=177)
Female	67	33	100 (N=268)
$X^2 = 4.288$, $p = < 0.05$			
Race			
White	71	29	100 (N=367)
Black	65	35	100 (N= 43)
Hispanic	68	32	100 (N= 31)
Other	75	25	100 (N= 4)
$X^2 = 5.65$, non-significant			
Country of Origin			
U.S.A.	71	29	100 (N=173)
Puerto Rico	62	38	100 (N= 26)
Italy	55	45	100 (N= 38)
Eastern Europe	68	32	100 (N= 93)
Western Europe (excluding Italy)	88	12	100 (N= 40)
Other	68	32	100 (N= 41)
Unknown (N=34)			
$X^2 = 10.86$, $df = 5$, $p = < 0.05$			
Neighborhood Condition			
Poor	62	37	100 (N= 89)
Average	72	28	100 (N=232)
Good	78	22	100 (N= 87)
Unknown (N=37)			
$X^2 = 8.09$, $df = 4$, $p = < 0.08$			

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community study", in *Dependency in the Elderly of NYC*, Community Council of Greater New York, October, 1978.

CHART 9: Computation of Institutionalization Rates for Elderly by Age, Marital Status, and Living Arrangement Prior to Institutionalization (Both Sexes) : U.S. 1973-74

	Nursing Home Population a/	Noninstitutionalized Population b/	Estimated Institutionalization Rate/1000
65-74			
Married	30,100	8,087,300	4
Widowed	75,100	3,538,700	21
Alone	29,800	2,262,000	13
Relatives	41,000	1,169,400	34
Non-relatives	4,300*	107,200	39
Never Married/Div/Sep	57,900	1,345,600	41
Alone	20,700	762,300	26
Relatives	33,200	480,800	65
Non-relatives	4,000*	102,400	38
75-84			
Married	54,800	2,648,800	20
Widowed	263,400	3,060,600	79
Alone	109,700	1,852,200	56
Relatives	145,200	1,105,800	116
Non-relatives	8,400	102,600	76
Never Married/Div/Sep	66,700	586,500	102
Alone	35,300	316,000	100
Relatives	27,800	222,900	111
Non-relatives	3,600*	47,600	70
85+			
Married	32,200	252,400	113
Widowed	328,600	867,300	275
Alone	131,400	373,000	261
Relatives	188,400	454,600	293
Non-relatives	8,800	39,700	181
Never Married/Div/Sep	52,800	110,500	323
Alone	30,300	54,000	359
Relatives	19,100	43,400	306
Non-relatives	3,500*	13,100*	211

a/ Estimates based on data from the 1973-74 National Nursing Home Survey

b/ Data from the 1973-74 Health Interview Surveys

* Figure does not meet NCHS standards of reliability or precision

Source: National Center for Health Statistics

CHART 10: Computation of Institutionalization Rates for Elderly by Age, Marital Status, and Living Arrangement Prior to Institutionalization (Males) : U.S. 1973-74

	Nursing Home Population a/	Noninstitutionalized Population b/	Estimated Institutionalization Rate/1000
65-74			
Married	15,600	4,540,800	3
Widowed	17,600	538,300	32
Alone	7,100	323,800	21
Relatives	8,700	190,400	44
Non-relatives	1,800*	24,100*	69
Never Married/Div/Sep	31,800	545,300	55
Alone	12,900	309,800	40
Relatives	17,800	183,700	88
Non-relatives	1,100*	51,800	21
75-84			
Married	28,500	1,676,800	17
Widowed	46,900	552,600	78
Alone	20,600	310,500	62
Relatives	24,800	216,900	103
Non relatives	1,400*	25,200*	53
Never Married/Div/Sep	26,900	208,800	114
Alone	14,800	109,600	119
Relatives	11,200	79,100	124
Non-Relatives	900*	20,100*	43
85+			
Married	18,900	187,500	92
Widowed	64,300	199,800	322
Alone	25,800	89,200	224
Relatives	37,400	105,300	262
Non-Relatives	1,200*	5,300*	185
Never Married/Div/Sep	15,000	31,800	321
Alone	7,300*	15,500*	320
Relatives	5,900*	11,400*	341
Non-relatives	1,700*	4,900*	258

a/ Estimates based on data from the 1973-74 National Nursing Home Survey

b/ Data from the 1973-74 Health Interview Surveys

* Figure does not meet NCHS standard of reliability or precision

Source: National Center for Health Statistics

CHART 11: Computation of Institutionalization Rates for Elderly by Age, Marital Status, and Living Arrangement Prior to Institutionalization (Females) : U.S. 1973-74

	Nursing Home Population a/	Noninstitutionalized Population b/	Estimated Institutionalization Rate/1000
65-74			
Married	14,500	3,546,500	4
Widowed	57,500	3,000,400	19
Alone	22,700	1,938,200	12
Relatives	32,200	979,100	32
Non-relatives	2,600*	83,100	30
Never Married/Div/Sep	25,900	800,300	31
Alone	8,200	452,500	18
Relatives	15,200	297,100	49
Non-relatives	2,600*	50,600	49
75-84			
Married	26,300	972,000	26
Widowed	216,500	2,507,900	79
Alone	89,200	1,541,600	55
Relatives	120,300	888,900	119
Non-relatives	7,000	77,400	83
Never Married/Div/Sep	39,800	377,760	95
Alone	20,700	206,500	91
Relatives	16,500	143,800	103
Non-relatives	2,600*	27,500	86
85+			
Married	13,300	64,800	170
Widowed	264,400	667,500	284
Alone	105,700	283,800	271
Relatives	151,200	349,300	302
Non-relatives	7,600	34,400	181
Never Married Div/Sep	37,500	78,700	323
Alone	22,400	38,500	368
Relatives	13,200	32,000	292
Non-relatives	1,900*	8,200*	188

a/ Estimates based on the 1973-74 National Nursing Home Survey

b/ Data from the 1973-74 Health Interview Surveys

* Figure does not meet NCHS standards for reliability or precision

Source: National Center for Health Statistics

CHART 12: Responses to Cantor Study Question "Who Would You Turn to in Various Situations Other than Spouse?" (Percent Distribution)

	KIN			NONKIN						
Type Of Assistance	**Child**	**Relative**	**Total**	**Friend**	**Neighbor**	**Total**	**Formal Organization**	**No One**	**N/A**	**Total**
Instrumental Health										
1. Suddenly feel sick or dizzy	28.9	13.4	42.3	11.4	13.3	24.7	14.6	17.9	2.0	100.0 (N=1552)
2. Accident, need someone to help, to come in every day to bathe you and give medicine	30.7	15.1	45.8	12.8	8.4	20.2	14.3	15.8	3.7	100.0 (N=1552)
3. Help going to doctor	28.9	13.3	42.2	15.7	11.5	27.2	10.9	18.9	1.7	100.0 (N=1552)
Financial										
1. Do not have enough money for big medical bill	24.6	9.7	34.3	6.4	2.1	8.5	20.6	35.3	2.4	100.0 (N=1552)
2. Need to borrow few dollars until check comes	27.5	12.3	39.8	13.8	5.0	18.8	6.0	36.0	1.0	100.0 (N=1552)
Other Tasks of Daily Living										
1. Need new light bulb in ceiling	19.9	6.9	26.8	5.7	8.5	14.2	17.1	41.7	1.0	100.0 (N=1552)
2. Look after apt., when in hospital	31.6	17.8	49.4	13.7	11.5	25.2	4.8	18.0	3.1	100.0 (N=1552)
3. Fill out a form	32.6	12.2	44.8	13.0	8.0	21.0	4.7	28.8	1.1	100.0 (N=1552)
Affective										
1. Talk about problem concerning child or someone in family	23.3	17.6	40.9	18.9	7.9	26.8	4.4	26.0	2.5	100.0 (N=1552)
2. Feel lonely and want to talk	24.3	13.5	37.8	27.3	12.8	40.1	1.7	19.5	2.3	100.0 (N=1552)

Source: Cantor, Marjorie, "Neighbors and Friends: An Overlooked Resource in The Informal Support System", a paper presented at the 30th Annual Meeting of the Gerontological society, San Francisco, CA, November, 1977.

CHART 13: Distribution of Caregivers by Relationship to Care Receiver, Sex and Type of Caregiving Arrangement (Base Numbers in Hundreds)

Sex and Relationship	**Elderly Couples Living Alone**	**Elderly Couples Living With Others**	**Unmarried Elderly Living With Others**
Male			
Husband	46.9	32.4	—
Son or son-in-law	—	0.6	6.6
Other male relative[1]	—	0.1	9.7
Female			
Wife	53.1	e2.2	—
Daughter or daughter-in-law	—	1.5	11.8
Other Female relative	—	3.1	71.8
Total	100.0	100.0	100.0
N	(4853)	(1287)	(6185)

[1] May include children or children-in-law, siblings and other relatives. Because relationship was recorded with reference to the household head, it was in many cases impossible to determine the exact nature of the relationship of the caregiver to care receiver.

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

CHART 14: Distribution of Caregivers by Need for Assistance Score (NAS)[1], NAS of Care Receiver, Type of Caregiving Arrangement and Age Group of Caregiver (Base Number in Hundreds)

		Type of Arrangement and Age of Caregiver					
		Elderly Couples Living Alone		Elderly Couples Living With Others		Unmarried Elderly Living with Others	
NAS of Caregiver	NAS of Care Receiver	<65	65+	<65	65+	<65	65+
0	8 - 11	32.0	38.2	20.1	29.6	45.4	41.2
	12 - 14	65.5	54.3	79.6	64.7	52.0	52.5
1 - 7	8 - 11	1.1	0.7	0.3	1.9	0.2	1.2
	12 - 14	0.4	1.7	0.0	2.3	1.0	3.0
8 - 14	8 - 11	0.0	2.2	0.0	1.5	0.7	0.1
	12 - 14	1.0	2.9	0.0	0.0	0.6	2.0
TOTAL		100.0	100.0	100.0	100.0	100.0	100.0
N		(733)	(4170)	(369)	(918)	(5018)	(1167)

[1] Need for Assistance Score: 0 = none, 1-7 = low, 8-11 = moderate, 12-14 = high

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

CHART 15: Distribution of Caregivers By Per Capita Household Income Group, Race, Type of Caregiving Arrangement and Caregiver Labor Force Status (Base Number in Hundreds)

	Type of Arrangement					
	Elderly Couples Living Alone		Elderly Couples Living With Others		Unmarried Elderly Living With Others	
Race and Per Capita Income	In Labor Force	Not In Labor Force	In Labor Force	Not In Labor Force	IN Labor Force	Not In Labor Force
White						
$1-2199	13.5	27.9	20.2	23.0	8.2	23.3
2200-3399	23.4	31.3	42.0	25.5	14.3	26.2
3400-5299	20.9	26.3	20.0	33.3	27.3	24.9
5300+	42.2	14.5	18.1	18.2	50.2	25.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
N	(550)	(4017)	(152)	(882)	(2414)	(2817)
Non-White						
$1-2199	16.0	57.3	—	56.5	39.4	70.4
2200-3399	45.7	32.1	—	19.3	29.9	12.7
3400-5299	22.6	5.2	—	5.9	15.0	15.8
5300+	15.8	5.5	67.2	18.2	15.7	1.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
N	(67)	(219)	(41)	(211)	(509)	(446)

— Too few cases are available for reliable estimation

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

CHART 16: Relationship Between Age and Institutional Equivalents of Service Received

Age	Institutional Equivalents of Service: Limited Home Care (N=44)	Adult Home (N=45)	Nursing Home (N=43)	Total (N=132)
	Percent of Age Group			
65-69	46	29	25	100 (N=24)
70-74	48	21	31	100 (N=28)
75-79	25	47	28	100 (N=32)
80-84	28	36	36	100 (N=24)
85-89	25	50	25	100 (N=12)
90-94	0	22	78	100 (N= 9)

Unknown (N=1)

$X^2 = 80.4$
significance $p = < 0.001$

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Study" in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 19: Family Contacts, Persons Age 65 and Over, By Age and Incapacity Score: 1975[a] (Percentages)

Family Contacts and Age Group	Incapacity Score 0-4	5+
Saw child during past 24 hrs.		
65-69	39	36
70-74	39	52
75-79	40	67
80+	48	61
All Ages	41	54
Saw child during previous week		
65-69	58	42
70-74	60	59
75-79	59	76
80+	67	79
All Ages	60	65
No family contact during previous week		
65-69	20	28
70-74	19	22
75-79	22	11
80+	17	12
All Ages	20	18

[a] Excludes bedfast persons

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 17: The Level of Support Service Given to Persons With Personal Time Dependency (PTD) By Severity of Dependency

Institutional Equivalent of Support Service	Severity of PTD: Minor Percent	Minor Number of Cases	Moderate Percent	Moderate Number of Cases	Severe Percent	Severe Number of Cases	Total Percent	Total Number of Cases
Limited Home Care	23	31	9	11	2	2	34	44
Adult Home	5	7	24	30	5	8	34	45
Nursing Home (HRF & SNF)	0	0	2	2	30	41	32	43
Total	28	38	35	43	37	51	100	132

Source: Gurland, Barry et. al, "Personal Time Dependency in the Elderly of New York City: Findings from the U.S.-U.K. Cross National Geriatric Community Study," in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 18: Source of Services for Elderly of Different Impairment Level (Percent Distribution)

Impairment level	Family and friends (percent)	Agency (percent)
Unimpaired	59	41
Slightly	57	43
Mildly	63	37
Moderately	70	30
Generally	67	33
Greatly	71	29
Extremely	80	20

Source: "Home Health — The need for a National Policy to Better Provide for the Elderly", U.S. General Accounting Office, Washington D.C., 1977.

CHART 20: Time Commitment and Level of Skill of the Support System: Primary Providers Only[1]

Time per Week	Level of Skill: Nursing	Personal Care	House-keeping	Admin./ errands	Company	N	%
Full-time (80 hrs)	2	13	1			16	12
Daily (40 hrs)		23	9			32	24
Half-days (16 hrs)		4	19	1	1	25	19
Short sessions (8 hrs)		4	14	20	3	41	31
Weekly (4 hrs)*		1	6	10	1	18	14
N	2	45	49	31	5	132	
%	2	34	37	23	4		100

1 Primary provider defined as the one who gives the service judged most critical to maintaining the subject at home.

*The category "less than weekly" is empty in this instance.

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*, Community Council of Greater New York, October, 1978.

CHART 21: Responses to Sherwood Study Question "If More Help Needed, Could Family and/or Friends Be Relied Upon to Provide It?" By Type of Sample***

	Deflected From Institutional Residency	Urban Black	Urban Puerto Rican	Urban Ethnic	Rural	Residents of High Rise Facility for Aged	Total
Very confident	32.2%	24.2%	30.0%	49.7%	38.1%	48.7%	39.8%
Fairly confident	16.5	33.9	16.0	17.0	23.7	18.1	20.1
Somewhat confident	9.8	17.6	8.0	6.4	10.5	12.7	10.8
Less than confident	16.5	17.6	26.0	16.3	13.2	6.6	14.4
Not confident	24.8	7.7	20.0	10.6	14.5	13.9	14.9
Number of Cases	121.0	91.0	50.0	141.0	76.0	166.0	645.0

*** Chi-square significance ___ $\leq$ .001
** Chi-square significance ___ $\leq$ .01 but $>$ .001
* Chi-square significance ___ $\leq$ .05 but $>$ .01

Source: Sherwood, S., "Meeting the Needs of the Impaired Elderly: The Power and Resiliency of the Informal Support System," Hebrew Rehabilitation Center for the Aged, Boston, 1981.

CHART 22: Responses to Sherwood Study Question Regarding Number of Informal Helpers Subject Can Rely Upon In Future By Type of Sample***

	Deflected From Institutional Residency	Urban Black	Urban Puerto Rican	Urban Ethnic	Rural	Residents of High Rise Facility for Aged	Total
0	49.0%	24.8%	22.0%	45.7%	15.4%	30.0%	34.5%
1	14.8	26.7	18.0	15.2	20.5	19.4	18.6
2	18.1	24.8	30.0	17.2	20.5	18.8	20.2
3	13.4	20.8	18.0	13.2	15.4	25.9	18.0
4	4.7	3.0	12.0	8.6	28.2	5.9	8.7
Number of Cases	149.0	101.0	50.0	151.0	78.0	170.0	699.0

*** Chi-square significance ≤ .001

Source: Sherwood, S., "Meeting the Needs of the Impaired Elderly: The Power and Resiliency of the Informal Support System," Hebrew Rehabilitation Center for the Aged, Boston, 1981.

CHART 23: Variables Related To Incentive Liked Best (Dichotomy)

	Incentive liked best					
	N			Percent		
Variable	Service	Economic	Total	Service	Economic	Total
Race						
white	80	79	159	49.7	50.3	100.0
black	51	116	167	30.5	69.5	100.0
Sex						
male	8	30	38	21.1	78.9	100.0
female	123	168	291	42.3	57.7	100.0
Strength of ethnic identification						
no identification	88	123	211	41.7	58.3	100.0
very strong to strong	40	53	93	47.3	53.0	100.0
weak	2	17	19	10.5	89.5	100.0
Religious preference						
none	5	24	29	17.2	82.8	100.0
Protestant	72	92	164	43.9	56.1	100.0
Roman Catholic	39	50	89	43.8	56.2	100.0
other	15	26	41	36.6	63.4	100.0
Marital status						
not married	29	70	99	29.3	70.7	100.0
married	101	125	226	44.7	55.3	100.0
Has older person ever lived with respondent in own household						
no	80	151	231	34.6	65.4	100.0
yes	50	45	95	52.6	47.4	100.0
Has respondent ever taken care of an older person						
no	64	132	196	32.7	67.3	100.0
yes	67	63	130	51.5	48.5	100.0

Source: Sussman, Marvin B., "Social and Economic Supports and Family Environments for the Elderly," Bowman Gray School of Medicine, Wake Forest University, 1979.

CHART 24: Costs of the Support System: Primary Providers Only (In Dollars)[1]

Time per Week	Levels of Skill: Nursing	Personal Care	House-Keeping	Administration Errands	Company	Total
Full-time	286	1849**	143	—	—	2278
Daily	—	3329**	1170**	—	—	4499
Half-daily	—	232	988**	43	54	1317
Short sessions	—	116	364	423	81	984
Weekly	—	14	18	106	13	151
Total	286	5540	2683	572	148	9229

** High dollar-volume categories N=132

1. Primary provider defined as the one who give the service judged most critical to maintaining the subject at home.

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*, Community Council of Greater New York, October, 1978.

CHART 25: Estimated Weekly Cost of Care

Housing	$1,200
Food	1,275
Out-of-Pocket Medical	533
Imputed Value of Attendant Care	11,614
Miscellaneous	300
Total	$14,922

Source: Whitfield, S., "Maryland State Office for the Aging Family Support Demonstration Program", in *Financial Incentives for Informal Caregiving*, Community Council of Greater New York, New York City, 1982.

CHART 26: Descriptive Statistics of the Variables Included in the Soldo Study Analysis for Households Purchasing and Providing Care for an Elderly Person[1]

	All Households	Type of Family Involvement: Purchase	Provide
Age of Head of Household			
Mean Age	51.6	51.0	52.5
Household Income			
Mean Income	$13,033.7	$19,930.3	$16,317.6
Family Size			
Mean Family Size	3.2	3.2	3.1
Health Care Demands			
Percentage of Households with an Impaired Person	4.7	1.6	9.3
Race of Household Head			
Percentage of Households Headed by Whites	92.5	94.1	90.2
Child-Rearing Demands			
Percentage of Households with Children < 5 Years Old	8.4	8.8	7.8
Percentage of Households with Children 6 to 17 Years Old	27.6	27.8	27.3
Demands of Labor Force Participation			
Percentage of Households with Wife in Labor Force Containing No Other Women > 18 Years Old	30.6	49.6	2.3
Percentage of Households with Wife in Labor Force Containing At Least One Other Woman > 18 Years Old	3.6	3.3	4.1

1. Study sample extracted from the 1976 Survey of Income and Education was specified to include single family husband/wife households headed by a person less than 65 years of age that were either providing care on the premises or paying for care in an institution for one or more persons aged 65 and over.

Source: Soldo, Beth, "Family Caregiving to the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

CHART 27: Distribution of Caregivers in Soldo Study By Type of Household and Number of Children in Household. (Base Number in Hundreds)

Number of Children Under 18 in Household	Type of Arrangement: Elderly Couples Living Alone	Elderly Couples Living With Others	Unmarried Elderly Living with Others
None	100.0[1]	66.4	78.1
1 - 2	—	26.1	15.9
3+	—	7.5	5.9
TOTAL	100.0	100.0	100.0
Number of Additional Care Receivers			
None	100.0[1]	88.3	95.2
1 - 2	—	11.7	4.8
TOTAL	100.0	100.0	100.0
N	(4853)	(1287)	(6185)

[1] By definition, households where an elderly couple lives alone cannot have children under 18 or additional care receivers.

Source: Soldo, Beth, "Family Caregiving and the Elderly: Prevalence and Variation," based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01.

CHART 28: Personal Time Dependency and General Positive Attitude of Key Supports

General Attitude**	Dependency*: Non-Dependent, Dependent but Could Live at Home — Percent	Non-Dependent, Dependent but Could Live at Home — Number of Cases	Dependent and Could Require Institutional Care — Percent	Dependent and Could Require Institutional Care — Number of Cases	Percent of Total (N=162)
High (Positive) 43-45	22.6	29	2.9	1	18.5
Medium 32-42	64.1	82	61.8	21	63.6
Low (Negative) 17-31	13.3	17	35.3	12	17.9
Total	100.0	128	100.0	34	100.0

$X^2 = 12.93$, df = 2, $p < .001$

* For this analysis, dependency was dichotomized and separated into those who were either non-dependent or dependent, but could live at home; and those who were rated as requiring support analogous to that provided by an institutional setting.

** General attitude, normally a continuous variable ranging from 17 to 45, was trichotomized at plus and minus one standard deviation from the mean.

Source: Teresi, J. et. al., "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 29: Personal Time Dependency and Institutional Decision-Making

Institutional Decision-Making *	Dependency: Non-Dependent, Dependent but Could Live at Home — Percent	Dependency: Non-Dependent, Dependent but Could Live at Home — Number of Cases	Dependency: Dependent and Could Require Institutional Care — Percent	Dependency: Dependent and Could Require Institutional Care — Number of Cases	Percent of Total (N=162)
High 5-11	8.6	11	20.6	7	11.1
Medium 1-4	54.7	70	55.9	19	54.9
Low 0	36.7	47	23.5	8	34.0
Total	100.0	128	100.0	34	100.0

$X^2 = 4.86$, df = 2, $p < .09$

* Institutional decision-making was trichotomized so that a high score on this scale means more discussion of plans with family and professionals as to the possibility of placing the older person in an institution.

Source: Teresi, J. et. al., "Personal Time Dependency and Family Attitudes", *in Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 30: General Attitude and Institutional Decision-Making

General Attitude	Institutional Decision-Making: Low 0 — Percent	Low 0 — Number of Cases	Medium 1-4 — Percent	Medium 1-4 — Number of Cases	High 5-11 — Percent	High 5-11 — Number of Cases	Percent of Total (N=162)
High (positive) 43-45	14.5	8	22.5	20	11.0	2	18.5
Medium 32-42	72.7	40	61.8	55	44.5	8	63.6
Low (negative) 17-31	12.7	7	15.7	14	44.5	8	17.9
Total	100.0	55	100.0	89	100.0	18	100.0

$X^2 = 11.70$, df = 4, $p < .02$

Source: Teresi, J. et.al., "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 31: General Attitude and Family Orientation

Orientation *	General Attitude: Low 17-31 — Percent	Low 17-31 — Number of Cases	Medium 32-42 — Percent	Medium 32-42 — Number of Cases	High 43-45 — Percent	High 43-45 — Number of Cases	
High 34-39	0.0	0	63.3	19	36.7	11	100%
Medium 27-33	16.3	17	65.4	68	18.3	19	100%
Low 17-26	42.9	12	57.1	16	0.0	0	100%
Total (N=162)	17.9	29	63.6	103	18.5	30	

$X^2 = 26.01$, df = 4, $p < .0001$ * Family orientation was trichotomized at plus and minus one standard deviation from the mean.

Source: Teresi, J. et al, "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 32: Institutional Decision-Making and Family Orientation

Family Orientation	Institutional Decision-Making: Low 0		Medium 1-4		High 5-11		
	Percent	Number of Cases	Percent	Number of Cases	Percent	Number of Cases	
High 34-49	43.3	13	56.7	17	0.0	0	100%
Medium 27-33	32.7	34	56.7	59	10.6	11	100%
Low 7-26	28.6	8	56.4	13	25.0	7	100%
Total (N=162)	34.0	55	54.9	89	11.1	18	

$X^2 = 9.73$, df = 4, $p < .05$

Source: Teresi, et. al., "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 33: Inconvenience and General Attitude

Inconvenience	General Attitude: Low (Negative) 17-31		Medium 32-42		High (Positive) 43-45		
	Percent	Number of Cases	Percent	Number of Cases	Percent	Number of Cases	
High 1-14	40.0	10	60.0	15	0.0	0	100%
Low 0	13.8	19	64.2	88	22.0	30	100%
Total (N=162)	17.9	29	63.6	103	18.5	30	

$X^2 = 13.60$, df = 2, $p < .001$

Source: Teresi, et. al., "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 34: Inconvenience and Institutional Decision-Making

Inconvenience	Institutional Decision-Making: Low 0		Medium 1-4		High 5-11		
	Percent	Number of Cases	Percent	Number of Cases	Percent	Number of Cases	
High 1-14	20.0	5	52.0	13	28.0	7	100%
Low 0	36.5	50	55.5	76	8.0	11	100%
Total (N=162)	34.0	55	54.9	89	11.1	18	

$X^2 = 9.33$, df = 2, $p < .009$

Source: Teresi, J et. al.,"Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

CHART 35: Inconvenience and Dependency

Inconvenience	Dependency: Low — Non-Dependent, Dependent but Could Live at Home		Dependency: High — Dependent and Could Require Institutional Care		
	Percent	Number of Cases	Percent	Number of Cases	
High					
1-14	36.0	9	64.0	18	100%
Low					
0	86.9	119	13.1	18	100%
Total					
(N=162)	79.0	128	21.0	36	

$X^2 = 29.99$, df = 1, $p < .0001$

Source: Teresi, et. al., "Personal Time Dependency and Attitudes", in *Dependency in the Elderly in NYC*. Community Council of Greater New York, October, 1978.

CHART 36: Degrees to Which Caregiver Worries About Carereceiver's Situation By Type of Caregiver (Means and One-Way Anova)

Group	Carereceiver's Health	Carereceiver's State of Mind	Carereceiver's Financial Condition	Obtaining Sufficient Help For Carereceivers
Spouse	3.92	3.25	3.32	2.57
Child	3.82	2.95	2.50	3.44
Relative	3.95	3.10	2.67	3.60
Friend/Neighbor	3.42	2.28	1.44	2.50
Total Group	3.83	3.01	2.73	3.42
Main Effect-F	4.116*	2.150	8.846**	4.328*
df	3, 105	3, 104	3, 103	3, 102

*$p \leq .01$
**$p \leq .001$

Scale: 1-not at all; 2-rarely; 3-sometimes; 4-quite a lot

Source: Cantor, M., "Factors Associated with Strain Among Family, Friends and Neighbors Caring for the Frail Elderly," paper presented at the 34th Annual Gerontological Society Meeting, Toronto, Canada, November, 1981.

CHART 37: Degree of Strain Experienced By Caregiver Arising From Caring Role By Type of Caregiver (Means and One-Way Anova)

Group	Emotional	Physical	Financial
Spouse	1.76	1.76	1.41
Child	1.63	1.34	.85
Relative	1.57	1.19	.52
Friend/Neighbor	.71	.94	.24
Total Group	1.56	1.41	.91
Main Effect-F	8.204*	6.313**	10.556**
df	3, 106	3, 106	3, 106

*$p \leq .01$
**$p \leq .001$

Scale: 0-2, no impact to great deal of impact

Source: Cantor, M., "Factors Associated with Strain Among Family, Friends and Neighbors Caring for the Frail Elderly," paper presented at the 34th Annual Gerontological Society Meeting, Toronto, Canada, November, 1981.

CHART 38: The Frequency of Definite Depression in Association with Personal Time Dependency

Definite Depression	Independent (N=313)		Personal Time Dependent (N=132)	
	Percent	Number of Cases	Percent	Number of Cases
Absent (N=409)	93	290	87	115
Present (N= 38)	7	23	13	17
Total	100	313	100	132

$x^2 = 3.16$, $p < 0.07$

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study." in *Dependency in the Elderly of NYC. Community Council of Greater New York, October, 1978.*

CHART 39: The Frequency of Definite Depression in Independent (Not Personal Time Dependent/PTD) Companions 65 Years and Over

Definite Depression	Independent Companions of Non-PTDs (N=96)		Independent Companions of PTDs (N=44)	
	Percent	Number of Cases	Percent	Number of Cases
Absent (N=130)	96	92	86	38
Present (N= 10)	4	4	14	6
Total	100	96	100	44

$x^2 = 4.08$, $p = < 0.05$

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 40: The Frequency of Conjunction of Definite Depression and Personal Time Dependency (PTD) in the Same Household (Couples Over 65 Only)

Definite Depression in Household	PTD in Household Absent (N=48)		Present (N=44)	
	Percent	Number of Cases	Percent	Number of Cases
Absent (N=78)	94	45	75	33
Present (N= 14)	6	3	25	11
Total	100	48	100	44

$x^2 = 6.25$, $p = < 0.05$

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. — U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 41: Links Between Personal Time Dependency (PTD) and Depression*

Characteristics Associated with PTD	Depression
Dementia	.14
Heart disorders	.18
Neurological disorders	.17
Physical illness (Total)	.47
Immobility	.42
Perceptual Impairment	.17
Financial Disadvantage	.26
Inadequate Activities	.40

* This sample size is 445 so that all correlations of a magnitude greater than .09 are significantly different from zero.

Source: Gurland, Barry et. al., "Personal Time Dependency in the Elderly of New York City: Findings from the U.S. —U.K. Cross-National Geriatric Community Study", in *Dependency in the Elderly of NYC*. Community Council of Greater New York, October, 1978.

CHART 42: Assistance Received From Formal and Informal Supports Prior To and During Receipt of Homemaker Services By Type of Assistance

Task and Type of Helper	N=54 Have a Spouse		N=82 Have no Spouse but have One or More Children		N=40 Have no Spouse or Children but have Other Relatives, Friends or Neighbors	
Task: Heavy Housework	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	55.6	35.2**	28.0	18.2**	12.5	12.5
Formal	11.1	68.5*	14.6	68.3*	22.5	75.0*
Needs no Assistance	35.2	9.2**	61.0	23.1*	62.5	22.5*
Task: Personal Care	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	38.8	29.6	6.1	8.5	15.0	7.5
Formal	9.2	59.2*	7.3	43.9*	5.0	60.0*
Needs no Assistance	57.4	25.9*	87.8	51.2*	90.0	37.5*
Task: Light Housework	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	48.1	40.7	18.3	13.4	10.0	7.5
Formal	9.2	57.4*	8.5	70.7*	10.0	72.5*
Needs no Assistance	42.6	11.1*	74.4	19.5*	80.0	25.0*
Task: Fix Things in Apt	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	38.9	42.6	43.6	35.3**	20.0	15.0
Formal	35.2	53.7*	32.9	43.9*	45.0	62.5*
Needs no Assistance	33.3	16.7*	48.8	29.3*	35.0	27.5*
Task: Prepare Meals	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	57.4	68.4*	17.1	26.8*	15.0	10.0
Formal	—	13.0*	3.6	32.9*	5.0	50.0*
Needs no Assistance	42.6	27.8*	81.7	51.2*	82.5	42.5*
Task: Shop for Groceries	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	66.7	74.1	50.0	64.6*	37.5	32.5
Formal	3.7	27.8*	8.5	46.3*	32.5	75.0*
Needs No Assistance	35.2	13.0*	51.2	25.6*	37.5	5.0*
Task: Travel to Doctor	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	59.3	64.8	40.2	61.0	20.0	35.0*
Formal	14.8	29.6*	13.4	37.8*	35.0	57.5*
Needs no Assistance	35.2	14.8*	47.6	14.6*	47.5	25.0*
Task: Pick up Mail	**Prior**	**During**	**Prior**	**During**	**Prior**	**During**
Informal	53.6	72.2*	28.0	43.9*	25.0	40.0*
Formal	1.8	9.2	—	12.2*	2.5	22.5*
Needs no Assistance	44.4	20.3*	73.1	48.8*	72.5	45.0*

The differences between the percentages of people receiving help "prior" and "during" homemaker services were tested with McNemar's Test for the difference between correlated proportions, corrected for continuity.

* = increase $p < .05$
** = decrease $p < .05$

Source: Lewis, M.A., Bienenstock, R., Cantor, M., Schneewind, E., "The Extent to Which Informal and Formal Supports Interact to Maintain the Older People in the Community," paper presented at the 33rd Annual Meeting of The Gerontological Society, San Diego, CA., November, 1980.

CHART 43: Persons Aged 65 and Over Living With, Near, and at a Distance From Their Children and Persons Aged 65 and Over With No Children Who Had Seen Their Doctor Within Different Periods: 1975[a] (Percent Distribution)

When Last Saw Doctor	Persons Sharing Household With Child: All	Persons Sharing Household With Child: Ill in Bed During Past Year	Living Within 10 Minutes Journey Of Child: All	Living Within 10 Minutes Journey Of Child: Ill in Bed During Past Year	Living at a Distance of More Than 10 Minutes Journey: All	Living at a Distance of More Than 10 Minutes Journey: Ill in Bed During Past Year	Person With No Living Children: All	Person With No Living Children: Ill in Bed During Past Year
Within Past Month	36	44	36	52	32	48	28	52
Within Past Year[b]	48	50	44	42	50	44	50	45
More Than 12 Months Ago or Never	16	6	20	6	18	8	22	3
Total	100	100	100	100	100	100	100	100
N (weighted) =	(781)	(265)	(1521)	(376)	(2138)	(569)	(1167)	(229)

[a] Excludes bedfast persons.
[b] Excludes within past month

Source: Shanas, Ethel, "The National Survey of the Aged", University of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report 1977.

CHART 44: Percent Distribution of Respondents in Horowitz Study Ranking Program as First or Second Choice

Economic Programs	Percent Ranking as First	Percent Ranking as Second
Monthly Check	44.0	29.9
Food Stamps	22.5	31.6
Income Tax Deduction	17.6	18.6
Rental or Property Tax Deduction	11.0	13.6
Low-Cost Housing Improvement Loan	4.9	6.2
Total	100.0	100.0
(n)	(182)	(177)
Service Programs		
Medical Care	33.5	30.3
Homemaking	31.5	30.8
Social Center	14.0	12.1
General Services	11.5	13.1
Community Planning Agency	8.0	5.6
Short-Term Care Center	1.5	8.1
Total	100.0	100.0
(n)	(200)	(198)

Source: Horowitz, A., "Social and Economic Incentives for Family Caregivers," in *Financial Incentives for Informal Caregiving*. Community Council of Greater New York, New York City, February, 1982.

CHART 45: Elderly and Total Population, Projections 1980 to 2050 By Decade

Decade	Total Population of All Ages*	Elderly Population in Age Groups*				Elderly Population as Percentage of Total Population of All Ages			
		65+	65-74	75-84	85+	65+	65-74	75-84	85+
1980	222,159	24,927	15,493	7,140	2,294	11.2	7.0	3.2	1.0
1990	243,513	29,824	17,804	9,140	2,881	12.2	7.3	3.8	1.2
2000	260,378	31,822	17,436	10,630	3,756	12.2	6.7	4.1	1.4
2010	275,335	34,837	19,776	10,485	4,575	12.7	7.2	3.8	1.7
2020	290,115	45,102	28,128	12,199	4,776	15.5	9.7	4.2	1.6
2030	300,349	55,024	31,853	17,489	5,681	18.3	10.6	5.8	1.9
2040	308,400	54,925	27,018	19,927	7,980	17.8	8.8	6.5	2.6
2050	315,622	55,494	28,867	17,103	9,523	17.6	9.1	5.4	3.0

*Numbers in thousands

Source: New York State Office for the Aging, based on data from The Bureau of Census, *Projections of the United States: 1977 to 2050* (Series II Projections)

CHART 46: Elderly and Total Population Projections of Decade By Decade Increases, 1980 to 2050*

Years	Increase in 65+ Group		Increase in 65-74 Group		Increase in 75-84 Group		Increase in 85+ Group		Increase in 75+ Group		Increase in Total Population	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1980 - 1990	4897	19.6	2311	14.9	2000	28.0	587	25.6	2587	27.4	21,354	9.6
1990 - 2000	1998	6.7	- 368	- 2.1	1490	16.3	875	30.4	2365	19.7	16,865	6.9
2000 - 2010	3015	9.5	2340	13.4	- 145	- 1.4	819	21.8	674	4.7	14,957	5.7
2010 - 2020	10265	29.5	8352	42.2	1714	16.3	201	4.4	1915	12.7	14,780	5.4
2020 - 2030	9922	22.0	3725	13.2	5290	43.4	905	18.9	6195	36.5	10,234	3.5
2030 - 2040	- 99	- 0.2	-4835	-15.2	2438	13.9	2299	40.5	4737	20.4	8,051	2.7
2040 - 2050	569	1.0	1849	6.8	-2824	-14.2	1543	19.3	-1281	- 4.6	7,222	2.3

*Numbers in thousands

Source: New York State Office for the Aging, based on data from Bureau of the Census, *Projections of the Population of United States: 1977 to 2050* (Series II Projections)

CHART 47: Past and Projected Cohort Fertility Rates

Birth Year of Female	Year of Attaining Age 75	Completed Cohort Fertility Rate *
1905	1980	2.365
1910	1985	2.292
1915	1990	2.438
1920	1995	2.759
1925	2000	2.977
1930	2005	3.204
1935	2010	3.177
1940	2015	2.800
1945	2020	2.281
1950	2025	1.990
1955	2030	1.911
1960	2035	1.925
1965	2040	1.958
1970	2045	2.007
1975	2050	2.051
1980	2055	2.082
1985	2060	2.097
1990	2065	2.100

* Average number of children that would be born to a woman born between July 1 year and July 1 of previous year if she were to survive the childbearing period.

Source: Social Security Administration, *Actuarial Study No. 85*, 1980 (intermediate assumptions used for projections)

CHART 48: Life Expectancy at Age 65, 1960 to 2050

Year	Life Expectancy at age 65 * Males	Females	Difference between males and females
1960	13.0	16.1	3.1
1965	13.0	16.6	3.6
1970	13.2	17.2	4.0
1975	13.7	18.1	4.4
1980	14.3	18.7	4.4
1982	14.5	19.1	4.6
1985	14.8	19.5	4.7
1990	15.3	20.3	5.0
1995	15.6	20.8	5.2
2000	15.8	21.1	5.3
2005	16.0	21.4	5.4
2010	16.1	21.6	5.5
2020	16.4	22.0	5.6
2030	16.7	22.4	5.7
2040	17.0	22.8	5.8
2050	17.3	23.2	5.9

* The life expectancy for any year is the number of years of life remaining to a person if that person were to experience the death rates by age assumed for the selected year.

Source: Social Security Administration *1982 Annual Report of the Trustees*

CHART49: Percentage of Persons Having ADL Dependency and Percentage of Persons in Nursing Homes, By Age

Age Group	(1) Percent Having ADL Dependency*	(2) Percent Residing in Nursing Homes	(3) Ratio Between (2) and (1)
45-64	1.2%	.3%	.24
65-74	3.5%	1.4%	.40
75-84	11.3%	6.4%	.56
85+	35.1%	21.6%	.61

* These include all persons who either reside in a nursing home or reside in the community and are dependent in one or more activities of daily living.

Source: Combined data from the 1977 National Nursing Home Survey and the 1977 National Health Interview Survey (unpublished data), as published in Health Care Financing Administration, *Long Term Care: Background and Future Directions, 1981*.

CHART 50: Dependency Ratios, 1960 to 2050

Year	Dependency Ratios Aged *	Total **
1960	.174	.915
1965	.182	.950
1970	.184	.900
1975	.189	.828
1980	.195	.753
1985	.202	.709
1990	.215	.709
1995	.225	.713
2000	.226	.705
2005	.225	.683
2010	.236	.683
2015	.265	.714
2020	.303	.765
2025	.346	.821
2030	.378	.859
2035	.386	.864
2040	.380	.856
2045	.372	.847
2050	.374	.853

* Population aged 65 and over as ratio to population age 20-64

** Population 65 and over plus population under 20 as ratio to pop. 20-64 Source: Social Security Administration, *1982 Annual Report of the Trustees*

CHART 51: Elderly/Offspring Dependency Ratios, Projections 1980 to 2050

	Elderly Age Group			
	65-74	75-84	85+	All Elderly
1980	.731	.636	.542	.680
1990	.636	.653	.644	.642
2000	.558	.567	.656	.571
2010	.629	.494	.556	.572
2020	.852	.569	.489	.702
2030	.920	.765	.584	.819
2040	.878	.804	.776	.834
2050	.854	.768	.814	.819

Source: New York State Office for the Aging. Based on data from Bureau of the Census, *Projections of the Population of the United States: 1977-2050*, Social Security Administration, *Actuarial Study No. 85*.

CHART 52: Family Care Dependency Ratios,* Projections 1980 to 2050

	Elderly Age Group			
	65-74	75-84	85+	All Elderly
1980	.026	.072	.190	.059
1990	.022	.074	.226	.057
2000	.020	.064	.230	.056
2010	.022	.056	.195	.057
2020	.030	.064	.172	.063
2030	.032	.086	.205	.076
2040	.031	.091	.273	.091
2050	.030	.087	.286	.093

* Ratios of dependent elderly to offspring

Source: New York State Office for the Aging, based on data from Bureau of the Census, *Projections of the Population of the United States: 1977-2050*, Social Security Administration, Actuarial *Study No. 85*, and Health Care Financing Administration, *Long Term Care: Background and Future Directions*

CHART 53: Marital Status of Selected Age Groups, Projections 1980 to 2040

		Married		Not Married **	
		Number *	Percentages	Number	Percentages
Age 40-64					
	1980	45,637	78.9	12,204	21.1
	1990	49,926	75.2	16,504	24.8
	2000	63,838	75.6	20,588	24.4
	2020	69,711	72.3	26,663	27.7
	2040	69,653	73.9	24,575	26.1
Age 65-74					
	1980	9,874	62.9	5,816	37.1
	1990	11,543	63.0	6,777	37.0
	2000	11,069	60.3	7,306	39.7
	2020	19,485	64.3	10,818	35.7
	2040	18,487	62.5	11,111	37.5
Age 75-84					
	1980	3,265	42.6	4,398	57.4
	1990	4,684	45.9	5,526	54.1
	2000	5,794	47.0	6,529	53.0
	2020	7,017	47.8	7,669	52.2
	2040	12,201	50.2	12,126	49.8
Age 85 and over					
	1980	536	20.7	2,053	79.3
	1990	874	24.3	2,723	75.7
	2000	1,356	25.6	3,949	74.4
	2020	1,833	24.5	5,650	75.5
	2040	3,583	28.2	9,121	71.8
Total elderly (65+)					
	1980	13,675	52.7	12,266	47.3
	1990	17,102	53.2	15,024	46.8
	2000	18,220	50.6	17,779	49.4
	2020	28,336	54.0	24,135	46.0
	2040	34,271	51.4	32,358	48.6

* in thousands

** never married, divorced, or widowed

Source: New York State Office for the Aging, based on data from Social Security Administration *Actuarial Study No. 84*, 1980

CHART 54: Number and Percentages of Elderly With Great-Grandchildren, Projection 1980 to 2050 *

Year	Men		Women		All Elderly	
	Number	Percent	Number	Percent	Number	Percent
1980	3,015	30	6,162	42	9,177	37
1990	3,637	30	7,536	42	11,169	37
2000	3,988	31	8,324	44	12,312	39
2010	4,307	31	8,996	43	13,303	38
2020	5,448	30	11,112	42	16,560	37
2030	6,871	31	13,956	43	20,827	38
2040	7,143	33	14,886	45	22,029	40
2050	7,023	32	14,841	44	21,864	39

* numbers in thousands

Source: New York State Office for the Aging, based on data from Census Bureau, *Projections of the Population 1980 to 2050* and Shanas, E., "National Survey of the Aged," Univ. of Illinois at Chicago Circle, AoA Grant No. 90-A-369, Final Report, 1977.

APPENDIX B

Soldo Study Caregiver Selection Methodology*

Although the 1976 Survey of Income and Education (SIE) is an extremely large, comprehensive and national data base, it was not designed expressly to study caregiving patterns and hence posed problems common to secondary data analysis ... No variables in the SIE explicitly identify those households in which care was provided to an older person, or, within these households, which individual was the primary caregiver or care receiver. Full use was made of the existing data to overcome, to the extent possible, the data limitations of the SIE for the Soldo Study....

Structured characteristics were used to identify those households in the SIE that were likely to be caregiving arrangements. SIE households in which it is reasonable to assume that home-care was provided to an impaired older person were defined in the research as:

> multi-person households containing at least one person 65 years of age or older who required at least some assistance with either the activities of daily living or mobility.

Of the 151,170 households sampled in the SIE, 3101 (or 2.1 percent) households met the structural criteria used to define intra-household caregiving arrangements. It is important to note that because the sampling unit in the SIE is "the household," the analysis of caregiving is restricted only to *intra-household* caregiving arrangements....

A basic assumption underlying the operational strategy is that another member of the same household is the most likely *primary* care provider to an older functionally limited individual. It is not necessary to assume, however, that the individual(s) sharing the older person's household is the *only* care provider....

As part of the approach to identifying the study population, an index of functional status-the Need for Assistance Scale (NAS) — was developed. This scale was developed specifically for analyzing the SIE data on the elderly.

The Need for Assistance Scale was derived from responses to a sequence of three questions:

1. Does his/her health limit ability to do work around the house?
2. Does he/she need help eating, dressing, undressing or with personal hygiene?
3. Does he/she need help to go outdoors or get around outside home? ...

As noted above, SIE data do not specifically flag households in which nonmedical care is regularly provided to a household member. Nor do these data expressly identify the caregiver in such situations ... The first problem was dealt with by defining "intrahousehold caregiving arrangements" in terms of a set of implied structural characteristics. In overcoming the second type of data limitation, the researchers have relied on the existing research literature in the area to specify a hierarchy of probability-based caregiver assignment rules.

The first step in modifying the SIE ... was to compute a Need for Assistance (NAS) score for each individual in qualifying households. The "care receiver" role was then assigned to the individual 65 years of age or older with the highest NAS score. In a few instances of two-person households, both impaired individuals had approximately the same NAS score and no care receiver assignment was made. Instead, the household was coded as a "mutual support" arrangement. Of the 3101 eligible households only 2.1 percent (or 64 cases) were identified as mutual support arrangements.... It was impossible to identify unambiguously the care receiver in less than one percent of the eligible households (21 cases). These multi-person households contained two older persons with similar NAS scores who were similarily related to other members of the household (e.g., a household headed by middle-aged women and including only two older aunts whose NAS scores were approximately equal). In these few cases, the first older impaired person encountered in the household was arbitrarily assigned the primary care receiver role and the other impaired older person was coded as an additional care receiver incrementing the caregiving demands on the household....

Once the assignment of a primary care receiver was made within each of the 3101 eligible households, all other household members 18 years of age or over were initially considered eligible for assignment as the primary caregiver. For each of these eligibles, the difference between the NAS score of the designated care receiver and their score (the NAS Difference Score) was calculated. Only those household members whose NAS Difference Score exceeded three points were subsequently considered eligible for the caregiver assignment. In approximately 18 percent of the households meeting our structural criteria of a caregiving arrangement, this difference test was not met.... In an additional 16 percent of the structurally eligible households not only was the difference test failed but also the NAS scores were confined to a range of zero to three. Since we assumed that at least a three point NAS difference was necessary to infer quantitative differences in care needs, and NAS score of three could not be distinguished statistically from an NAS score of zero. In subsequent analyses, these 763 households were excluded since only minimal and periodic assistance (at best) was likely to be provided in households in which the maximum NAS score was less than or equal to three....

* The material in this section is quoted almost verbatim from Beth Soldo's *Family Caregiving to the Elderly: Prevalence and Variation*, based on special tabulation from the 1976 Survey of Income and Education (SIE) prepared by the Center for Population Research, Kennedy Institute of Ethics, Georgetown University, under AoA Grant No. 90-AR-2124/01, pp. 19, 24, 33-39.

The final study population was restricted to the 2274 households of the initial sample of 3101 that met the NAS difference criteria. Of these, nearly 60 percent (1826 cases) were two-person households and the assignment of the caregiver role was straight forward: by default, the primary caregiver role was assigned to the person other than the previously identified care receiver. In ten of these two-person households, the only person other than the impaired older individual was less than eighteen years of age. Although a caregiver assignment was made in these cases, it was considered an ambiguous one.

In order to make caregiver assignment in the remaining multiperson households in the final study population the researchers relied on the existing literature to indicate the most probable caregiver among the other household members. . . .

The Assignment Rules in Households with More than One Eligible. The review of the existing literature justified the formulation of a set of decision rules for assigning the caregiver role in households where more than one adult household member was "eligible" for that assignment. As noted above, the variables considered in the assignment decision were sex, age, relationship to the designated care receiver and the functional health status (as measured by the NAS) of each eligible adult in the household. The assignment rules are as follows:

Rule 1: Preference for Spouse. When available and regardless of sex, the spouse of the designated care receiver was given preference in the caregiver assignment. Preference was given to the spouse even if other adult family members were present in the household and even if the other family member(s) was less impaired than the spouse of the designated care receiver. These other adult members of the care receiver's household were coded as "secondary or backup caregivers." Exceptions to this rule were made in the following situations:

a. where both the elderly husband and wife had substantial functional limitations (i.e., the NAS of both exceeded ten) and another eligible adult in the same household had an NAS score at least three points lower than the NAS of the less impaired spouse. The more impaired spouse was designated the primary care receiver in this case and the other spouse was identified as a secondary care receiver. If there were more than one other adult eligible for the caregiver assignment, the choice between them was made on the basis of Assignment Rules 2 and 3.

b. where the NAS score of the least impaired spouse was in the range of five to nine, the difference between the NAS scores of the spouses exceeded three and another eligible adult was present in the household whose NAS score was at least three points lower than that of the least impaired spouse. If the second and third conditions were not met, the household was coded as a "mutual support" arrangement: if more than one other adult were eligible, Assignment Rules 2 and 3 were applied.

Rule 2: Preferences by sex and type of relationship. In households where the spouse was not present and more than one household member was eligible for the caregiver assignment by virtue of the NAS Difference Test, the caregiver designation followed a hierarchial ordering of daughter or daughter-in-law, son, younger female relative (not a child), older female relative, younger male relative (not a child), other male relative and finally a non-relative. This decision rule was evoked most often in husband-wife households where the impaired older person was identified on the SIE file simply as "another relative." In such situations the wife of the household head was assigned the caregiver role, *ceteris paribus*.

Rule 3: Preference in the case of a tie. In households where the application of Rules 1 and 2 failed to identify the most likely caregiver, preference was given to the first eligible person of those with identical characteristics. This rule was brought to bear, for example, in the case of an older impaired mother living with her two unimpaired daughters of the same age. Rule 3 dictated that the primary caregiver rule be assigned to the daughter whose record was first encountered. As noted above, the use of this tie-breaking rule is unlikely to have introduced substantial bias into the allocation procedures since the file was randomly sorted within type of relationship groups.

APPENDIX C

NYC DEPENDENCY STUDY MATERIAL

A. SERVICES TO PERSONS RESIDING IN THE COMMUNITY CONSIDERED AS EQUIVALENT OF INSTITUTIONAL SERVICES (WHERE REQUIRED FOR A DISABILITY)

Equivalent to Limited Home Care:

Any *one* of either shopping, cooking or housekeeping.

Equivalent to Adult Home (Domiciliary Care):

Any *two* of the following: Shopping, cooking, housekeeping; special accommodation or relocation to provide elevators or single level stairs; frequent administrative or semi-legal advice; constant company, security or encouragement; heavy chores.

Equivalent to Health-Related Facility or Skilled Nursing Facility:

Any of the above, plus supervision with bathing, walking, grooming and medications; changing bandages, care of incision, immediate response to falls or confusion; assistance with dressing, grooming, bathing, walking, shifting in bed, feeding, standing, care of incontinence, prevention of wandering or dangerous behavior, rehabilitation, observation for those who cannot communicate or are not aware of needs; includes individuals who require round-the-clock nursing services.

Source: Gurland, Barry et. al, "Personal Time Dependency in the Elderly of New York City: Findings from the U.S.-U.K. Cross National Geriatric Community Study," in *Dependency in the Elderly of NYC*, Community Council of Greater New York, October, 1978.

B. Scales Used in the Dependency Analysis

Scale I. **General Attitude***

1. _____ (elder) is usually open to new ideas and willing to change with the times.
2. Most of the time _____ (elder) is in good spirits and pleasant to be around.
3. _____ (elder) seldom interferes in the lives of relatives and other family and friends.
4. _____ (elder) is of great help in providing aid (chores, babysitting, etc.) to other family members.
5. _____ (elder) is usually neat and clean.
6. As children, we were taught to respect the elderly.
**7. _____ (elder) often does things which embarrass family members.
**8. _____ (elder)often makes people ill-at-ease and is hard to be around for long periods of time.
**9. Most of the time, elder is a burden to family and friends.

*Respondents were asked if they "strongly agreed", "neither agreed nor disagreed", "disagreed", or "strongly disagreed" with each of the above statements about their elderly relative.
** These items were scored in the opposite direction.

Scale II. **Institutional Decision-Making**

1. Amount of discussion of placement of (elder) in a nursing home or related institution by family member #1.	1 a little 2 a lot
2. Amount of discussion of placement of (elder) in a nursing home or related institution by family member or significant other #2.	1 a little 2 a lot
3. Amount of discussion of placement of (elder) in a nursing home or related institution by family member or significant other #3.	1 a little 2 a lot
4. If elder were to become ill, do you think you would place (elder) in a nursing home or health related facility.	1 maybe 2 probably would 3 definitely would
5. Suggestion of doctor regarding plans for the future of (elder) following discussion of _____ (elder's) condition.	Score 1 point for each of #5, 6, 7, 8, if any of the following responses were given:
6. Other suggestion of physician regarding plans for elder.	1. physician or professional suggested specific name of home.
7. Suggestion of other professional regarding plans for (elder's) future.	
8. Other suggestion of professional.	2. suggested nursing home if condition worsened, if incontinent, if senile or other.

Scale III. **Family Orientation***

1. In _____ (elder's) family, members often depend on each other for support in time of trouble.
2. As children, we were taught to respect the elderly.
3. In _____ (elder's) family, care for the older person is not a problem.
4. In _____ (elder's) family, care for the older person is usually shared by more than one family member.
5. It is important for others to think well of my family.
6. As children, we were taught that we should care for the older person if he/she needed help.
7. I remember most of my relationships with elderly relatives to be warm and pleasant ones.
** 8. As a child growing up, old people were not much a part of my life.

*Respondents were asked if they "strongly agreed", "agreed", "neither agreed nor disagreed", "disagreed", "strongly disagreed" with each of the above statement about their elderly relative.
** This Item was scored in the opposite direction.

Scale IV. **Inconvenience**

1. Amount of incovenience experienced by person #1 visiting older person	1 . . . somewhat inconvenienced 2 . . . quite inconvenienced
2. Willingness of person #1 to do it	1 . . . somewhat willing 2 . . . not willing
3. Amount of inconvenience visiting for person #2	same as #1
4. Willingness of #2	same as #2
5. Amount of inconvenience visiting for person #3	same as #1
6. Willingness of #3	same as #2
7. Amount of inconvenience experienced by person #1 doing household chores for older person	same as #1
8. Willingness of person #1 to do it	same as #2
9. Amount of inconvenience doing chores for person #2	same as #1
10. Willingness of #2 to do it	same as #2
11. Amount of inconvenience doing chores for person #3	same as #1
12. Willingness of #3 to do it	same as #2
13. Amount of inconvenience for persons #1 taking older person to appointments	same as #1
14. Willingness of #1 to do it	same as #2
15. Amount of inconvenience for #2	same as #1
16. Willingness of #2	same as #2
17. Amount of inconvenience for #3	same as #1
18. Willingness of #3	same as #2
19. Amount of inconvenience experienced by person #1 dressing/bathing elder	same as #1
20. Willingness of #1 to do it	same as #2
21. Amount of inconvenience for #2	same as #1
22. Willingness of #2	same as #2
23. Amount of inconvenience for #3	same as #1
24. Willingness of #3	same as #2

Source: Teresi, et. al., "Personal Time Dependency and Family Attitudes", in *Dependency in the Elderly in NYC*, Community Council of Greater New York, October, 1978.

APPENDIX D

Methodology For Dependency Ratios

Elderly/Offspring Dependency Ratios are ratios of the numbers of elderly to the numbers of younger people who are their offspring. Obtaining estimates of the numbers of elderly in future years is straightforward: Census Bureau population projections are available through 2050 for every five year age group. Population projections are cumulated to create totals for the 65-74 age group, the 75-84 age group, the 85+ age group, and the total 65+ group for each decade through 2050.

Obtaining estimates of the elderly's offspring in future years is more complicated and involves making more simplifying assumptions. An initial estimate of the number of offspring for each elderly age group is derived by applying cohort fertility rates from the Social Security Administration to the number of women in each elderly age group (cohort fertility rates indicate the average number of children born to a woman in that cohort who survives the childbearing period). This calculation involves making the assumption that elderly women are representative (in fertility rates) of all women in their cohort, whether or not they survived to old age.

These initial estimates of offspring are then refined to take into account two known problems with these initial estimates. First, the previously excluded offspring of widowed men are included by applying the cohort fertility rates of women of the same cohort to the numbers of widowed men in each age group. Thus, the assumption is made that widowed men have the same cohort fertility rates as do women of their ages. Secondly, the fact that some of the elderly's offspring have not survived is recognized by applying cohort survivorship rates (the proportion of the cohort that lives to a specific age) to the numbers of offspring.

Family Care Dependency Ratios are ratios of the numbers of dependent elderly to the numbers of younger people who are the elderly's offspring. The number of offspring is identical to that used in the previously described Elderly/Offspring Dependency Ratios (see above). The dependent elderly, however, represent only a portion of the elderly of each age group.

Projections of the numbers of dependent elderly in future years are made by applying current patterns of dependency with age to the projected population of individual age groups (65-74, 75-84, and 85+). The dependency numbers used are those from the National Health Interview Survey and the National Nursing Home Survey that indicate the percentages of elderly who are dependent in one or more activities of daily living (ADL). In 1977, 3.5 percent of the 65-74 group, 11.3 percent of the 74-84 group, and 35.1 percent of the 85+ group were ADL dependent.

APPENDIX E

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